AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name - Livingston Walker	Date of Birth - August 21, 1958	Social Security Number- 072-52-5988
Patient Address- 184 Primrose Avenue Bridgeport, CT 06606		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
East Coast Pain Management, P.C., 200 South Ridge Street, Rye Brook, NY 10573

8. Name and address of person(s) or category of person to whom this information will be sent:
Harrington, Ocko & Monk, LLP, 81 Main Street, White Plains, NY 10603

9(a). Specific information to be released:
- ☐ Medical Record from (insert date)_____ to (insert date)_____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other:_____

Include (indicate by Initialing)

_____Alcohol/Drug Treatment
_____Mental Health Information
_____HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize_____
Initials — Name of individual health care provider

To discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ **At request of the individual.** ☐ Other:	**This authorization will expire two (2) years from the date of execution.**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

Livingston J. Walker
Signature of patient or representative **Livingston Walker**
April ___, 2007

Sworn to before me this 27 Day of **April, 2007**

_____
Notary Public

JOHN J. BAILLY
Notary Public, State of New York
No 4835947
Qualified in Westchester County
Commission Expires November 30, 20 ___

*** Human Immunodeficienty Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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7. Name and address of health provider or entity to release this information:
Westchester Medical Center

8. Name and address of person(s) or category of person to whom this information will be sent:
Harrington, Ocko & Monk, LLP, 81 Main Street, White Plains, NY 10601

9(a). Specific information to be released:
- ☐ Medical Record from (insert date)_____ to (insert date)_____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other:_____

Include (indicate by Initialing)

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

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(b) ☐ By initialing here_____ I authorize_____
Initials — Name of individual health care provider

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(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ **At request of the individual.** ☐ Other:	**This authorization will expire two (2) years from the date of execution.**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

Livingston Walker
Signature of patient or representative **Livingston Walker**
April ___, 2007

Sworn to before me this 24 Day of **April, 2007**

_____
Notary Public

*** Human Immunodeficienty Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

JOHN J. BAILLY
Notary Public, State of New York
No 4635947
Qualified in Westchester County
Commission Expires November 30, 20[illegible]

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Patient Name - Livingston Walker	Date of Birth - August 21, 1958	Social Security Number- 072-52-5988
Patient Address- 184 Primrose Avenue Bridgeport, CT 06606		

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6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:
Rye Radiology Associates, LLP, 30 Ridge Plaza, Rye Brook, NY 10573

8. Name and address of person(s) or category of person to whom this information will be sent:
Harrington, Ocko & Monk, LLP, 81 Main Street, White Plains, NY 10601

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- ☐ Medical Record from (insert date)_____ to (insert date)_____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
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Include (indicate by Initialing)

_____Alcohol/Drug Treatment
_____Mental Health Information
_____HIV-Related Information

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(b) ☐ By initialing here_____ I authorize_____
Initials — Name of individual health care provider

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(Attorney/Firm Name or Governmental Agency Name)

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☐ **At request of the individual.** ☐ Other:	**This authorization will expire two (2) years from the date of execution.**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

Livingston J Walker
Signature of patient or representative **Livingston Walker**
April ___, 2007

Sworn to before me this 4th Day of **April, 2007**

_____
Notary Public

JOHN J. BAILLY
Notary Public, State of New York
No. 4835947
Qualified in Westchester County
Commission Expires November 30, 20 09

*** Human Immunodeficienty Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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Patient Address- 184 Primrose Avenue Bridgeport, CT 06606		

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7. Name and address of health provider or entity to release this information:
Kenneth E. Fox, M.D., 104 East 40th Street, Suite 803, New York, NY 10016

8. Name and address of person(s) or category of person to whom this information will be sent:
Harrington, Ocko & Monk, LLP, 81 Main Street, White Plains, NY 10601

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- ☐ Other:_____

Include (indicate by Initialing)

_____Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

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(b) ☐ By initialing here_____ I authorize_____
Initials — Name of individual health care provider

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Livingston J. Walker
Signature of patient or representative **Livingston Walker**
April ___, 2007

Sworn to before me this 24 Day of April, 2007

Notary Public

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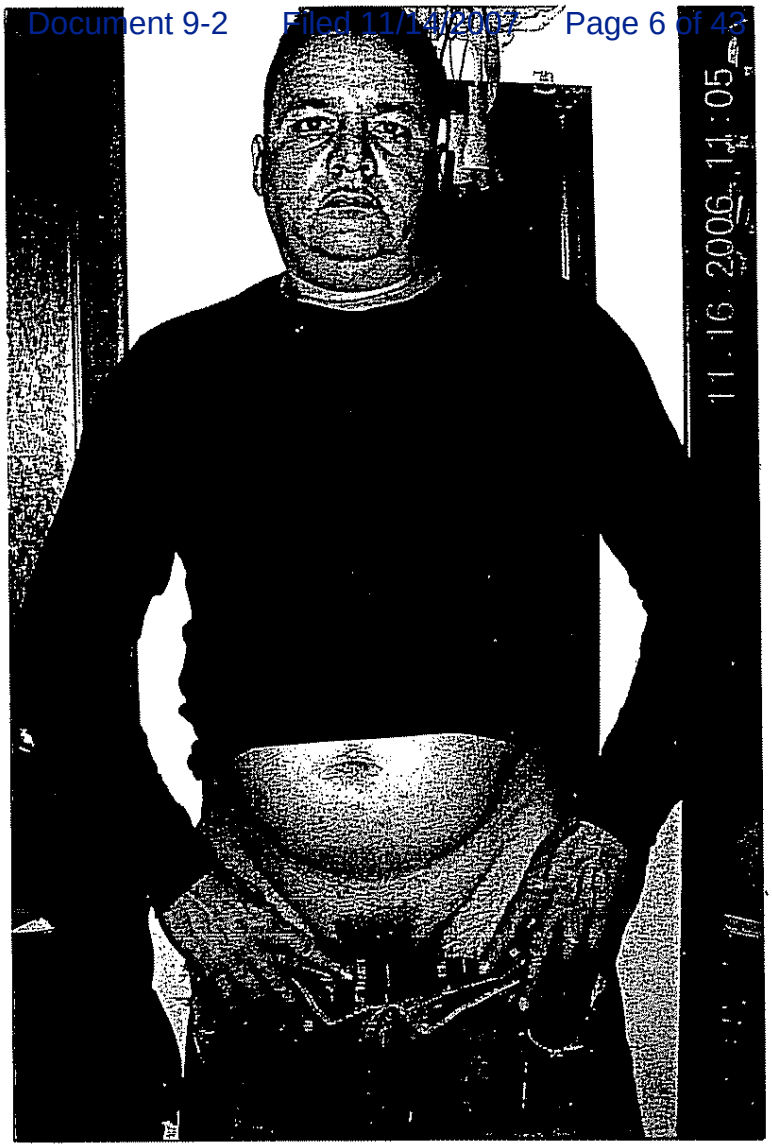
JOHN J. BAILLY
Notary Public, State of New York
No. 4835947
Qualified in Westchester County
Commission Expires November 30, 20__


11.20.2006 04:27


11.21.2006 22:27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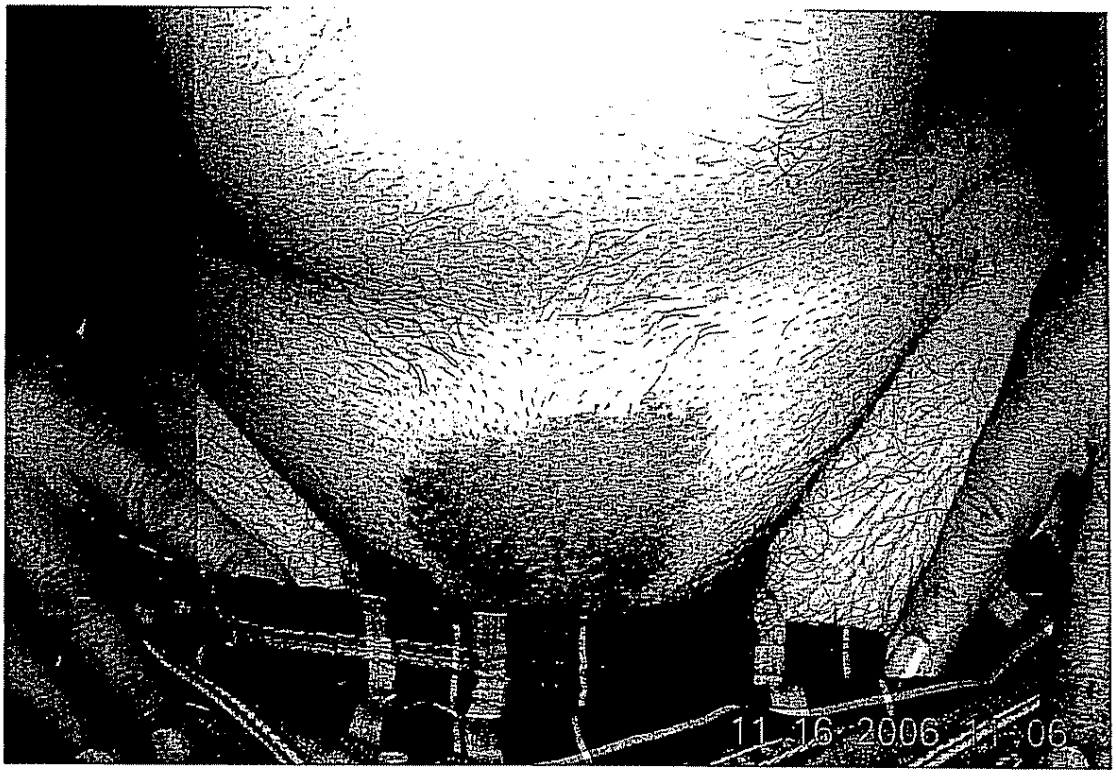

11 16 2006 11:06

RS Medical The Premier Electrotherapy Provider

Feb 1,2007

Walker Livingston
70 Pearl St
Port Chester, NY 10573-4611

Dear Walker,

Thank you for allowing RS Medical to participate in your health care. Your provider, Dr. Rudnick, has prescribed you a RS-LSO Spinal Orthosis for home therapy and we are pleased to provide it to you.

RS Medical's local representative, Nick Paparella, can assist you with questions you may have about the use of the RS-LSO Spinal Orthosis. Nick's phone number is 800-929-6766.

Our billing representative, Teri Price, can answer any billing or insurance questions you may have. Teri can be reached at 800-929-6867, please call at any time.

Sincerely,

Ashley Valdez
Sales Operations
866-775-0701

RS Medical *Advancing electrotherapy to relieve pain and improve function*

March 28, 2007 Account # 783063

Walker Livingston
70 Pearl St

Port Chester, NY 10573-4611

Dear Walker,

You are now receiving 2-inch square pads for use with your RS-LB Low Back Garment. RS Medical is discontinuing distribution of 3.5-inch pads. There are several reasons for this change:

Same high quality The two-inch squares are made to the same standards as the larger pads, delivering the same high quality and therapeutic value.

Great comfort The 2-inch squares are made from the same design and materials as the 3.5-inch pads, so their comfort characteristics are virtually identical. Many RS Medical customers have successfully used the 2-inch pads for years.

Better fit Two-inch square pads fit better. Because they are smaller, they are more pliable. Greater flexibility means the two-inch pads "wear" better. Users say handling smaller pads is easier, too.

Improved Battery Life The larger 3.5-inch pads generally require higher intensities to deliver the same level of stimulation as the smaller 2-inch pads. Using smaller pads will enable patients to reduce intensity levels during treatments, allowing longer treatments that deliver more therapy.

So why is RS Medical switching to two-inch square pads? To provide you with better fitting, comfortable, high quality, easier-to-use pads.

If you have a question, please call Customer Service at 1-800-935-7763, Monday-Saturday.

F88 A 1-31-07

RS Medical *Advancing electrotherapy to relieve pain and improve function*
14001 SE 1st Street • Vancouver, WA 98684
360-892-0339 • FAX 360-896-2566

April 5, 2007 Acct#: 783063

Walker Livingston
70 Pearl St

Port Chester, NY 10573-4611

Dear Walker:

Our office received a prescription from your physician for the indefinite use of our unit. We will be making contact with the primary payer (typically your insurance provider) on file for your account and reviewing the purchase options instead of indefinite monthly rentals.

To aid in this process, ***if your device is so equipped***, please remove the data card from its slot at the top of your unit and return it to our office, unless you have already done so.

If you are not sure if your device is equipped with a data card, please contact us so we may assist you.

If you have any questions or concerns please do not hesitate to call us at the number listed below.

Sincerely,

Lisa Lown
Benefit Verification Specialist
(800)446-6954

EAST COAST PAIN MANAGEMENT, P.C.

1207 ROUTE 9, SUITE 4
WAPPINGERS FALLS NY 12590
(845) 297- 3200

354 DOWNING DRIVE
YORKTOWN HEIGHTS, NY 10598
(914) 248- 1612

200 SOUTH RIDGE STREET
RYE BROOK NY 10573
(914) 939- 9248

EVALUATION AND MANAGEMENT REPORT
WC NF & P. Injury

PATIENT: Walker, Livingston (WC) DATE: 3/5/07

Reason for this Evaluation: ☐ Emergency Visit ☐ Visit at patient's request
☐ Scheduled visit after Initial Evaluation to review progress and Plan. ☒ Other, see Subjective

SUBJECTIVE, patients concerns and or complaints:

Pt here c/o MRI of LS
Testdone 2-28-07

OBJECTIVE, Physical findings (if unchanged, state date) and work up results:

BP: 150/85 HR: 72 RR: 15

Findings: DDD L5 S1
bulge L4-5 + L5 S1
Flavum hypertrophy L4 → S1

ASSESSMENT or diagnostic impression:
☐ See Diagnosis and therapy orders sheet

Findings discussed w/ pt.
waiting approval for further eval w/ EMG + plan

IF THIS IS A NEW CONDITION, MUST INDICATE IF IT IS: ☐CONSEQUENTIAL or ☐UNRELATED TO ACCIDENT ☐N/A

In case of Consequential Injury must explain mechanism: Tx based on results

Expected treatment and work-up for this Consequential injury: Therapy_____ times/week x_____ weeks.

Workup:

PLAN: See plan page attached.

3. Has MMI been reached? ☐Yes ☒No
7. Is CURRENTLY Working? ☒Yes ☐No
8. Disabled for regular work duties? ☒Yes ☐No
Disability is: ☐Total ☒Partial
Partial, Work Restrictions lift/carry/pull/push > 5

9. Impairment %:

ONLY After MMI has been reached: (if 3=YES)

10. Can patient do any type of work? ☐Yes ☐No
Describe Work Capacity per US-DOT: ☐Sedentary
☐Light ☐Medium ☐Heavy ☐Very Heavy

GLADYS CARDENAS, M.D.

PHYSICIANS NAME and SIGNATURE _____

FORM 113-1 2/3/2003

OFFICIAL NEW YORK STATE PRESCRIPTION

GLADYS E CARDENAS MD
200 SOUTH RIDGE STREET
RYE BROOK, NY 10573
(914) 939-9248
LIC 189011

PRACTITIONER DEA NUMBER BC 3338539

Patient Name Walker, Livingston Date 1/29/07

Address

City State Zip Age Sex M F

Rx

MRI C/S
R/O HNP

MAXIMUM DAILY DOSE (controlled substances only)

Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'daw' IN BOX BELOW

REFILLS None Refills:

Dispense As Written

0FYG8B 59

PHARMACIST TEST AREA

OFFICIAL NEW YORK STATE PRESCRIPTION

GLADYS E CARDENAS MD
200 SOUTH RIDGE STREET
RYE BROOK, NY 10573
(914) 939-9248
LIC 189011

PRACTITIONER DEA NUMBER BC 3338539

Patient Name Walker, Livingston Date 1/29/07

Address

City State Zip Age Sex M F

Rx

Xray
L Spine

MAXIMUM DAILY DOSE (controlled substances only)

Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'daw' IN BOX BELOW

REFILLS None Refills:

Dispense As Written

0FYG8B 58

PHARMACIST TEST AREA

SW CNYRxPadMV117774 P Pad 6 of 10 5/20/2006 N

OFFICIAL NEW YORK STATE PRESCRIPTION

GLADYS E CARDENAS MD
200 SOUTH RIDGE STREET
RYE BROOK, NY 10573
(914) 939-9248
LIC 189011

PRACTITIONER DEA NUMBER BC 333

Patient Name Walker, Livingston Date 1/29/07

Address

City State Zip Age Sex M F

Rx

Relafen 750
1 tab po BID
for pain #60

MAXIMUM DAILY DOSE (controlled substances only)

Prescriber Signature X

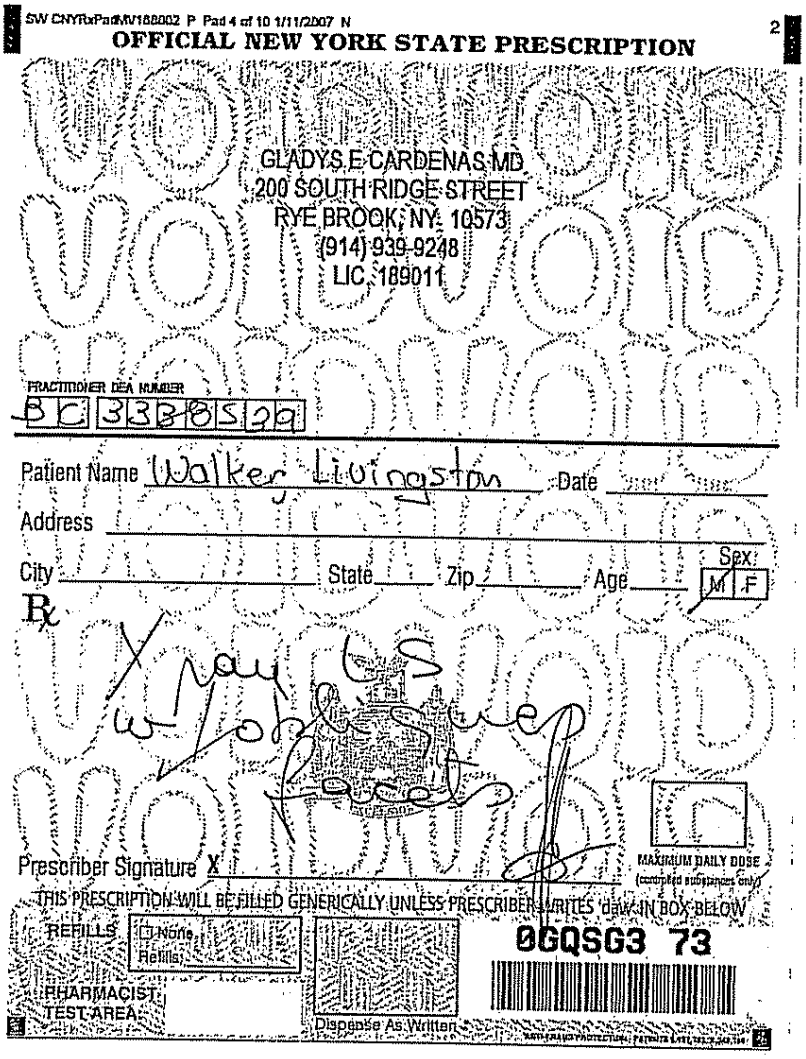
THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'daw' IN BOX BELOW

REFILLS None Refills: 1

Dispense As Written

0FYG8B 57

PHARMACIST



SW CNYRxPadMV188002 P Pad 4 of 10 1/11/2007 N

OFFICIAL NEW YORK STATE PRESCRIPTION

2

GLADYS E CARDENAS MD
200 SOUTH RIDGE STREET
RYE BROOK, NY 10573
(914) 939-9248
LIC 189011

PRACTITIONER DEA NUMBER
BC 3338529

Patient Name Walker Livingston Date

Address

City State Zip Age Sex: M F

℞

Prescriber Signature X

MAXIMUM DAILY DOSE
(controlled substances only)

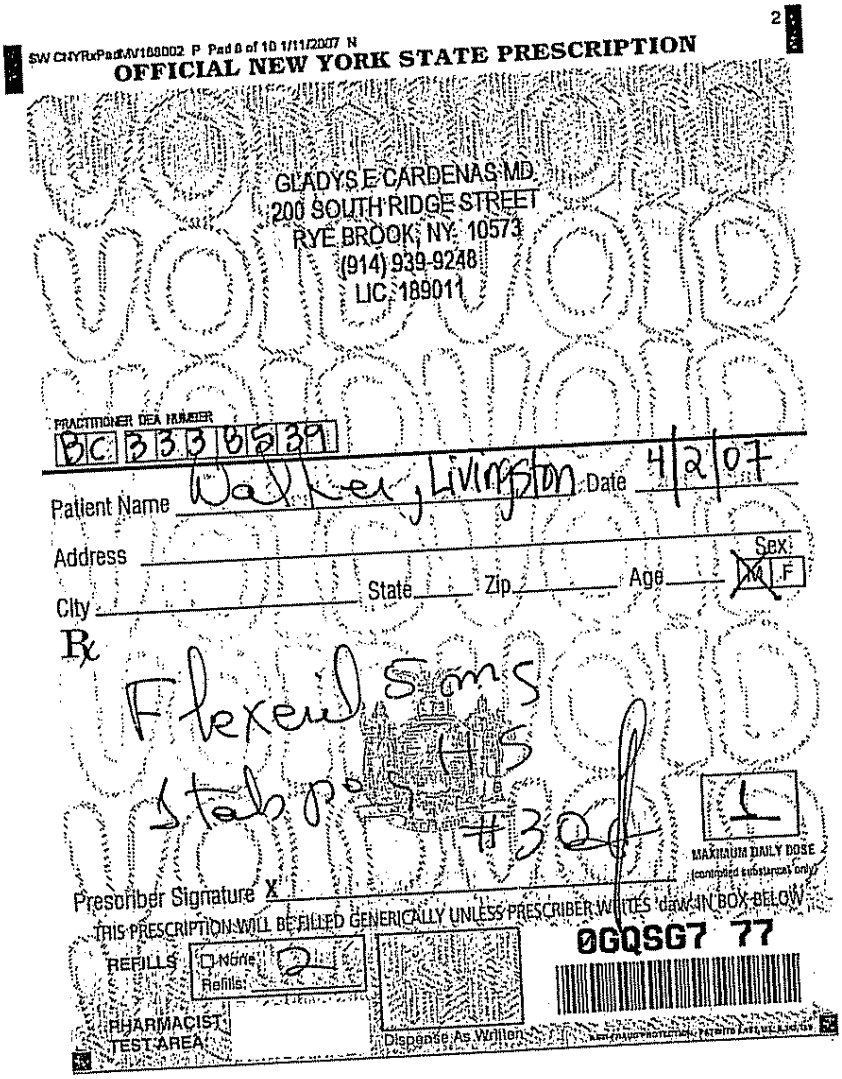
THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'DAW' IN BOX BELOW

REFILLS None Refills

0GQSG3 73

PHARMACIST TEST AREA

Dispense As Written



SW CNYRxPadMV160002 P Pad 8 of 10 1/11/2007 N

2

OFFICIAL NEW YORK STATE PRESCRIPTION

GLADYS E CARDENAS MD
200 SOUTH RIDGE STREET
RYE BROOK, NY 10573
(914) 939-9248
LIC 189011

PRACTITIONER DEA NUMBER
BC 3336239

Patient Name Walker, Livingston Date 4/2/07

Address

City State Zip Age Sex M F

Rx

Flexeril 5mg
1 tab po tid #30

MAXIMUM DAILY DOSE (controlled substances only) L

Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES daw IN BOX BELOW

0GQSG7 77

REFILLS None Refills: 2

PHARMACIST TEST AREA

Dispense As Written

CLINICAL CASE SUMMARY AGE 51						TODAY'S DATE: 1/8/07
NAME: Walker, Livingston	~~WC~~	NF	MC	INS	OP	IV: 1/8/07
DX: LBP						DOA: OTHER DX:
X-RAY:						X-RAY:
X-RAY:						X-RAY:
MRI: LS 2/07 bulges + DDD L5						MRI:
MRI:						MRI:
EMG:						NERVE BLOCKS:
EMG:						NERVE BLOCKS:
JOINT INJ:						JOINT INJ:
OTHER:						OTHER:
PAST MEDICAL HISTORY: HTN		PAST SURGICAL HISTORY: (-)				GENERAL MEDICATION: (-)
PAIN/OUR MEDS: Percocet Rx'd by Dr Fox, he takes once in a very while.						NOTES:
DISABILITY: INITIAL TOTAL PARTIAL CHANGES:						

East Coast Pain Management, P.C.

PRESCRIPTION TRACKING SHEET

RYE

Patient: Walker Livingston. DOB:

Allergies – Drug Reactions:

PAGE NUMBER:

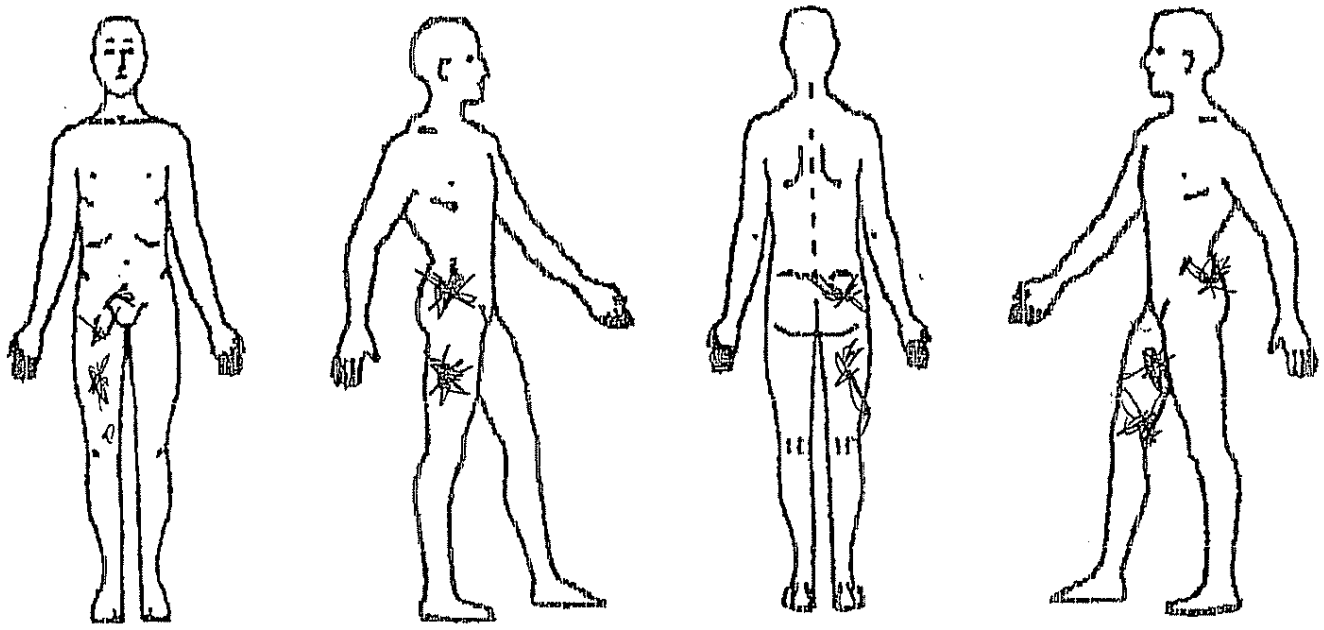
Patient Home Phone: Work Phone:

ODAY'S ISIT	*MEDICATION/STRENGTH/DIRECTION/REFILLS*	*ORDERING PHYSICIAN*	*NAME OF PHARMACY & PHONE NUMBER*	*INTIAL*
8/07	Percocet 7.5/500mg #80	Dr. Fox		AV.

EAST COAST PAIN MANAGEMENT P.C.
PAIN DIAGRAM Page 2 of 2

NAME Livingston Walker

ON THE DIAGRAM BELOW, SHADE THE AREA(S) WHERE YOU FEEL NUMBNESS OR TINGLING.
MARK WITH AN "X" WHERE NUMBNESS AND TINGLING FEEL WORSE.



REVIEWING PHYSICIAN's SIGNATURE Dr Kenneth Sox

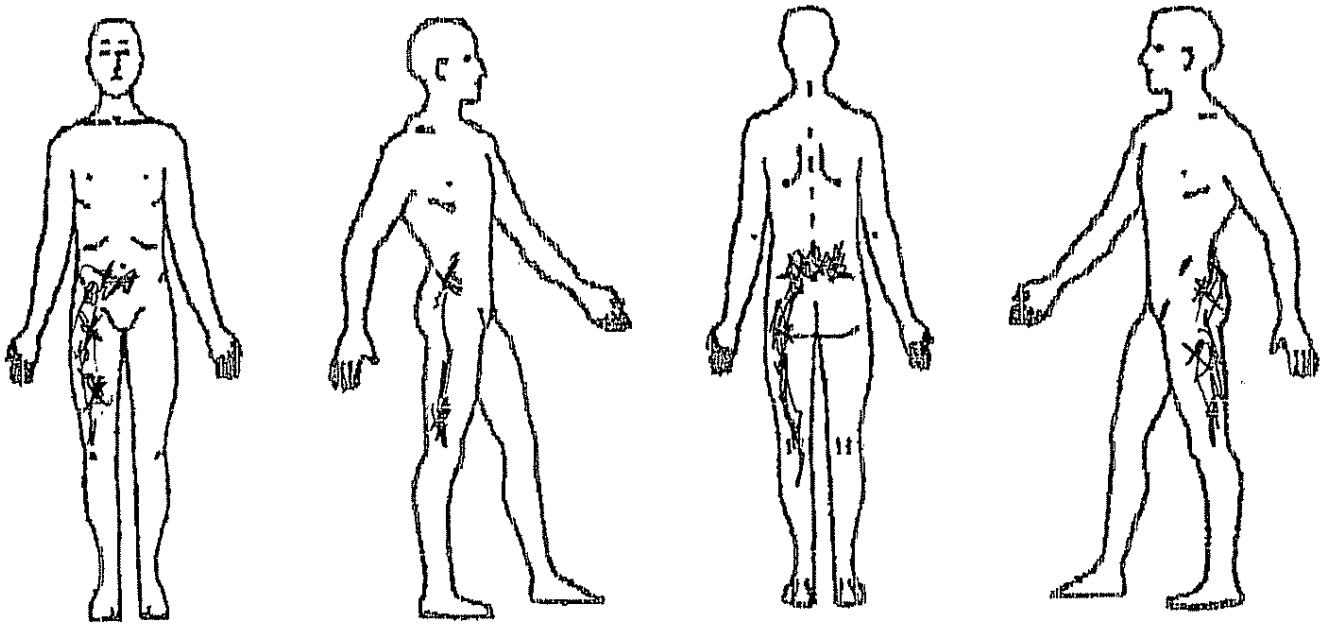
GLADYS CARDENAS, M.D.

EAST COAST PAIN MANAGEMENT P.C. DATE: 11/8/07

PAIN DIAGRAM Page 1of 2

NAME Walker Livingston

ON THE DIAGRAM BELOW, SHADE THE AREA(S) WHERE YOU FEEL PAIN.
MARK WITH AN "X" THE AREAS THAT HURT THE MOST.



Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	

REVIEWING PHYSICIAN's SIGNATURE Dr Kenneth Fox.

GLADYS CARDENAS, M.D.

INTAKE NF WC PI:

NAME (Walker, Livingston (WC)) DATE 11/8/07

PLEASE ANSWER ALL QUESTIONS 1-25: 1. Your age? 51 2. Date of the accident? 11/14/06

3. DESCRIBE HOW THE ACCIDENT OCCURRED:

*.

4. Did you go to the ER after the accident? (Yes) No, did you go by AMBULANCE? (Yes) No

5. Which HOSPITAL? WESTCHESTER MEDICAL CENTER, were X-Rays taken in the ER? (Yes) No

6. Which body parts were injured?

7. Did this accident happen DURING WORK HOURS? ☑Yes ☐No

8. As a result of this accident, have you been in significant pain for SIX months or more? ☐YES ☑NO

If NO, continue w/question ▶9. If YES, skip to question ≙14 and complete the PAIN INTAKE

▶9. Have you seen other doctors FOR THIS SAME PROBLEM? ☐Yes ☑No

Dr's name: _____ Last visit date _____

Dr's name: _____ Last visit date _____

10. Have you had Physical Therapy FOR THIS PROBLEM? ☐Yes ☑No 11. Last day of therapy _____

12. Have you had X-RAY, MRI or CT-Scans as result of this accident? ☑Yes ☐No If yes, please list below:

☐X-ray ☑MRI ☐CT of: TORSO Date NOV 14, 2006

☐X-ray ☐MRI ☐CT of: _____ Date _____

☐X-ray ☐MRI ☐CT of: _____ Date _____

13. Have you had SURGERY as a result of this accident? ☐Yes ☑No, if yes how many times? _____, list below:

Surgery type: _____ Last date of surgery: _____

Surgery type: _____ Last date of surgery: _____

Surgery type: _____ Last date of surgery: _____

PHYSICIAN'S NOTES:
PLEASE DO NOT WRITE IN THIS AREA

All Intake information was reviewed and discussed with the patient:
Dr.'s name and signature:

GLADYS CARDENAS, M.D.
D. Kenneth Sox

≙14. Name of your PRIMARY DOCTOR: _____, your last Physical Date July 2006

15. Your OCCUPATION at the time of the accident was? OPERATING ENGINEER

16. Have you lost time from work because of this accident? ☑Yes ☐No 17. How much time? (5) DAYS 18. Last date worked _____

19. You are now ☐Working PT ☑Working FT ☐LIGHT DUTY ☐Not Working, reason: _____

20. Has your occupation changed due to the accident? ☐Yes ☑No, if Yes explain why did it change: _____

21. PAST SURGERIES NOT RELATED TO THIS ACCIDENT, (please list all):

1) Type of Surgery _____ Date _____

2) Type of Surgery _____ Date _____

3) Type of Surgery _____ Date _____

4) Type of Surgery _____ Date _____

22. MEDICAL HISTORY: Circle if you have/had any of these conditions:

(1) High Blood Pressure
2. Diabetes
3. Asthma
4. Cancer
5. Ulcers
6. Arthritis
7. Heart Disease
8. Kidney Disease
9. Depression
10. Anxiety

11. Other conditions, Please Name:

23. DO YOU HAVE ANY OF THESE?

1. Difficulty hold/pass urine	Yes	No
2. Difficulty hold/pass stool	Yes	No
3. Headaches	Yes	No
4. Feel sad/cry easily	Yes	No
5. Shortness of Breath	Yes	No
6. Memory Loss	Yes	No
7. Ringing in ears	Yes	No
8. Severe weight loss	Yes	No
9. Pain that Wakes You Up	Yes	No
10. Allergies, name	Yes	No

ALLERGIC TO:

24. DO YOU HAVE DIFFICULTIES:

Walking	Yes	No
With Stairs	Yes	No
With Balance	Yes	No
With house chores	Yes	No
Getting off a chair	(Yes)	No
Getting out the car	(Yes)	No
Dressing yourself	(Yes)	No
Reaching	(Yes)	No
Do you Live alone?	Yes	(No)
Do you Drive?	(Yes)	No
Do you Fall often?	Yes	(No)

25. ALL MEDICATIONS & SUPPLEMENTS you take

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

T ORDERS AND Dx. WC/NF NAME: Walker, Livingston DATE: 1/8/07

[3 X week for 4 WEEKS — For reference WC units assigned per modality are in ( )

QUATIC (Rye ONLY) PT ____x/week — Symptomatic ____ x ____ for ____ — Internal use: 8 Units — PT ⊘ MD DRY ⊘ AQUA

ASSIVE MODALITIES	Area#1	Area#2	Area3
97010 Hot Packs(2)	/	/	
97032 Electrical Stim (2.5)	/	/	
97035 Ultrasound(2.5)	/	/	
97018 Paraffin Bath(2.5)			
97124 Massage (2.5)	/		

Passive used to: ☐↓Inflammation/edema ☐↓Spasm ☐Soften scars ☐Prepare for exercise ☐↓Joint Pain ☐↓Arthritic condition ☐↓Joint Pain

[ ] Progress PT as tolerated
[ ] PRN modalities
[ ] Pre-post PT Ice PRN

gnosis	EM	PT	Procedure
Lumbosacral s/s	/	/	
R) lumbosacral rad.	/	/	

billing purpose, check if diagnosis is related to PT program and/or visit and/or procedure ordered (specify procedure).

Dr Kenneth Fox
PHYSICIANS NAME and SIGNATURE

NAS, MD

97140 Manual Therapy

- ☑ Soft Tissue Mobilization (MFR)(4)
- ☐ Joint Mobilization(4)
- ☐ Manipulation(4) ☐ Manual Traction (4)

Manual used to: ☐↓Shortened tissue ☐↑ Fluid exchange ☐ Mobilize tissue w/edema ☐ ↑Mobility

97530 Functional Activities

- ☑ Trunk activities to ↑Bending
- ☐ UE / LE activities to ↑ Carrying
- ☐ UE / LE activities to ↑ Reaching
- ☐ UE activities to ↑Object Manipulation
- ☐ Activities to improve transfers
- ☐ Other:
- ☐ Activities to promote safe ambulation
- ☐ Activities to improve stair negotiation
- ☐ Other activities to improve function:
- ☐ Cervical activities to improve head turning
- ☐ Activities to improve bed mobility

(2.5 per 15 minutes)

97113 AQUATIC

RYE ONLY PLEASE !!! ☐ Core exercise ☐ No Jets ☐ UE exercise ☐ Walk only ☐ Progressive Jets ☐ LE exercise ☐ Progress to run

Used to : ☐↑ ROM ☐↑ Strength ☐↑ Endurance

97112 Neuro-Muscular Re-Education

- ☐ Cervical Stabilization
- ☐ Trunk Stabilization
- ☐ Upp. Extr. Re-Education
- ☐ Low. Extr. Re-Education
- ☐ Propioceptive Neuromuscularfacilitation
- ☐ Balance
- ☐ Coordination
- ☐ Desensitization

(3.5 per 15 minutes)

Used to: ☐↑Kinesthetic Sense ☐↑CS Posture ☐↑TS Posture ☐↑LS Posture ☐↑Propioception ☐↑Standing Balance ☐↑Gross Coordination ☐↑Fine Coordination ☐↑Muscle Tone ☐↓Muscle Tone

TAPING

29240 ☐Shoulder 29260 ☐Elbow ☐Wrist 29280 ☐Hand/Finger 29220 ☐Low back
29520 ☐Hip 29530 ☐Knee 29540 ☐Ankle (0.2-0.3 Surgical units)

97110 Therapeutic Exercises

THERAPEUTIC EXERCISE

ROM exercises: ☑ AROM ☐ AAROM ☐ PROM

STRETCH exercises: ☐ Active ☐ Assistive ☐ Prolonged static

NON RESISTED strengthening: ☐ CS ☐ TS/LS ☐ UE ☐ LE

ISOMETRIC exercises: ☐ CS ☐ TS/LS ☐ UE ☐ LE

ABDOMINAL strengthening: ☐ Pelvic Tilt ☐ Crunches

HAND exercises: ☐ ROM ☐ Strengthening

ISOTONIC strengthening: ☐ Thera-band ☐ Dumb-bells ☐ Ankle Weights

CIRCUIT ☐ Full Circuit: ☐ Cable Column ☑ Back Extension ☐ Resisted Crunch ☐ Multi Hip ☐ Leg Press ☐ Leg Curl ☐ Leg Extension

CARDIOVASCULAR: ☐ Bike ☐ Tread-Mill ☐ UBE ☐ Warm-up/Cool-down ☐ Strength extremities ☐ Cardiovascular work LIMIT to ____ % of Max HR for Age (=220 – age / %)

(3.5 per 15 min)

97537 Reintegration: ☐ Community ☐ Work Specific Function: (3)

97535 Self Care: Specific Need: ☐ HEP ☐ Maintenance ☐ other: (3) (Max 6 sessions) & follow : x weeks/months

SHORT TERM GOALS	PT LONG TERM GOALS
↑Functional Performance	☑ Max Function
↑ROM	☑ Max ROM
↑Strength	☐ Max Strength
↓Pain	☑ Pain level 0
Symptomatic benefit	☐ Symptomatic benefit
Per PT evaluation	☐ Per PT evaluation

Form 301-01 WC NF PT Orders and Dx revised 2/13/2006

CHECK BP & PULSE PRE-POST THERAPY ☐ CHECK BODY WEIGHT ____ X per Week. ☐ FALL PRECAUTIONS
CARDIAC PRECAUTIONS ☐ HIP PRECAUTIONS ☐ SEIZURE PRECAUTIONS

OM/MMT/PT evaluation: ☐ PT Evaluation ☐ ROM MMT Baseline ☐ ROM MMT prior to FU ☐ FCE

OM ☐ CS ☐ Trunk Shoulder ☐R - ☐L Elbow ☐R - ☐L Wrist ☐R - ☐L Hip ☐R - ☐L Knee ☐R - ☐L Ankle ☐R - ☐L Hand ☐R ☐L ☐R 1 2 3 4 5 ☐L 1 2 3 4 5
MT ☐ CS/UE ☐ Trunk /LE Shoulder ☐R - ☐L Elbow ☐R - ☐L Wrist ☐R - ☐L Hip ☐R - ☐L Knee ☐R - ☐L Ankle ☐R - ☐L Hand ☐R ☐L ☐R 1 2 3 4 5 ☐L 1 2 3 4 5
Grip ☐R - ☐L Pinch ☐R - ☐L Toe ROM ☐R 1 2 3 4 5 ☐L 1 2 3 4 5 †Digits Only†

PLAN PAGE

PATIENT: Walker Livingston DATE: 1/8/07

PT: 3 X week for 4 WEEKS ____ Water (Rye only) SYMPTOMATIC (WC/C ONLY): _____ X _____ for _____

☐Continue Physical Therapy ☐PT evaluation ____ PT visits for HEP instruction (max 6) ☐HEP

☐Discontinue PT ☐Hold PT ☐PT close to home/IC OK'd facility ☐FCE followed by EM w/FCE ☐ADL & Functional Evaluation

See PT Order and Diagnosis page for details of PT orders, PT goals and precautions

INJECTIONS: (May need pre-approval)

☐Trigger Point_____	Series of #____	Start_____ ☐ASAP	Interval____ weeks	
☐Tendon/lig/Ganglion/Fascia_____ ☐Medicare Carpal/Tarsal	Series of #____	Start_____ ☐ASAP	Interval____ weeks	
☐Peripheral Nerve _____	Series of #____	Start_____ ☐ASAP	Interval____ weeks	
☐Joint/Bursa _____	Series of #____	Start_____ ☐ASAP	Interval____ weeks	
☐*Paravertebral (Transforaminal) _____	Series of #____	Start_____ ☐ASAP	Interval____ weeks (2 min)	
☐*Facet Block, Level _____	Series of #____	Start_____ ☐ASAP	Interval____ weeks (2 min)	
☐*Epidural/Caudal, Level _____	Series of #____	Start_____ ☐ASAP	Interval____ weeks (2 min)	

* Necessity: ☐Painful radiculopathy ☐Facet Syndrome ☐Pain management ☐Inflammatory arthritis ☐Painful neuropathy ☐Diagnostic Block

EMG & NCV: (May need pre-approval) ☐ UPPER EXTREMITIES ☐ LOWER EXTREMITIES ☐ OTHER:

To evaluate for: ☐Radiculopathy ☐CTS ☐Myopathy ☐Neuropathy ☐Check for radiculopathy prior to Facet Block ☐Other:

RADIOLOGIC WORK UP: (May need pre-approval)

MRI of:	X-Ray of:	Other:
R/O ☐ HNP ☐ Int. Derange ☐ Other	R/O ☐ Fracture ☐ O.A. ☐ Bone pathology	R/O

LAB WORK UP: ☐ CBC ☐ Sed Rate ☐ EKG baseline ☐ UA ☐ Other:

☐ Blood Chem ☐ Arthritis profile ☐ LFT ☐ Urine Toxicology ☐ Other:

ORTHOSES & EQUIPMENT

☐ TENS UNIT	☐ Insoles	☐ Cock-Up Splint	☐ Wrist Brace
☐ C-Collar	☐ Cane	☐ Knee Brace	☐ Elbow cuff
☒ Ls Orthosis	☐ Walker	☐ Ankle Brace	☐ Electrical Stimulator

MEDS STRENGTH DOSE	Rx #	X
☐RELAFEN ☐NAPROSYN		
☐ULTRAM ☐CELEBREX		
☐SOMA ☐FLEXERIL ☐SKELAXIN		
TYLENOL ☐#3 ☐#4		
☐HYDROCODONE ☐VICODIN		
☐COMBUNOX ☒PERCOCET 7.5/500	#0	
☐ELAVIL ☐DESIPRAMINE		
☐CELEXA ☐ZOLOFT		
☐LIDOCAINE PATCH		
☐NEURONTIN ☐LYRICA		
☐ULTRACET		

MEDS STRENGTH DOSE	Rx#	X
☐KADIAN		
☐METHADONE		
☐OXYCONTIN		
☐OXYCODONE ☐OXY-IR		
☐FENTANYL PATCH		
☐MSIR ☐MSCONTIN		
☐ SIGN PAIN MANAGEMENT AGREEMENT ☐ Has Meds		

CONSULTATION: Dr: Specialty: (May need pre-approval)

☐ EM _____ ☐Two weeks EM ☐ EM following PT course(w/PTeval/ADL/ROM, if applies)

☐ EM ASAP for _____ ☒With records Westchester Med Ctr.

☐ EM for Pain Management/Meds in _____ ☐Schedule QV for Meds every _____ x _____

☐ Continue visits as previously planned ☐Return PRN ☐Discharge

☐ INSTRUCT the patient to fill a RESPONSE TO PAIN MEDICATION "take home" chart ____ days prior to the next visit.

Medication to be charted: 1- 2- 3- 4-

It is my professional opinion that the above plan is medically necessary to provide appropriate care for this patient.

LADYS CARDENAS, M.D. Dr. Kenneth Fox

DR. NAME AND SIGNATURE

INITIAL VISIT WC, NF and PEI ONAL INJURY Page 2

NAME (Walker, Livington DATE 11/8/07

Pain full/x ↓ ROM in L-spine

BACK (T-L&Lumbosacral):

- ☐ Scololosis
- ☐ Kyphosis
- ☐ TS Tenderness / ☐ Spasm R L
- ☒ LS Tenderness / ☐ Spasm (R L)
- ☐ Midline Tenderness
- ☐ Palpable Step
- ☒ Sacroiliac joint Tenderness R L
- ☐ Tenderness Sacrum/Coccyx
- ☐ ↓ Trunk ROM / ☐↓ Strength
- ☐ Functional ROM / ☐ with Pain

Trigger/tender points in: ☐ L-S paraspinal ☐ Q. Lumborum ☐ Gluteus ☐ Other

OTHER FINDINGS: Sacroiliac tenderness

LOWER EXTREMITIES: ___ Ø

- ☐ Thigh Atrophy R L
- ☐ Leg Atrophy R L
- ☐ Foot Atrophy R L
- Thigh Girdle R _____ cm L _____ cm. At 16 cm Proximal Upper Patella pole
- Calf Girdle R _____ cm L _____ cm. At 16 cm. Distal Lower Patella pole
- Leg length R _____ cm L _____ cm. ASIS to Medial Maleolus

OTHER FINDINGS:

☐ Functional ROM In both L.E.

Strength
- ↓ HIP FLEXORS R L
- ↓ QUADRICEPS R L
- ↓ HAMSTRING R L
- ↓ BIG TOE EXTENSOR R L
- ↓ PLANTAR FLEXORS R L

POSITIVE SLR (R) L

Right Hip NT ☐ Swelling ___ Ø

☐ Tenderness→ ☐ Subtrchanteric Bursa → ☐ Gluteal Bursa → ☐ Ischeal Bursa

☐ Difuse Tenderness ☐ ↓ ROM / ☐↓ Strength

Left Hip ☐ Swelling ___ Ø

☐ Tenderness→ ☐ Subtrchanteric Bursa → ☐ Gluteal Bursa → ☐ Ischeal Bursa

☐ Difuse Tenderness ☐ ↓ ROM / ☐↓ Strength

Right Knee Moderate Hamstring tightness ☐ Swelling ☐ Effusion

☐ Medial / ☐ Lateral Joint Line tenderness ☐ Positive McMurray

☐ Anterior Drawer ☐ Pivot Shift ☐ Posterior Drawer

☐Medial / ☐Lateral Ligament laxity. ☐ Unstable Patella ☐↓ROM / ☐↓ Strength

Left Knee ☐ Swelling ☐ Effusion ___ Ø

☐ Medial / ☐ Lateral Joint Line tenderness ☐ Positive McMurray

☐ Anterior Drawer ☐ Pivot Shift ☐ Posterior Drawer

☐ Medial / ☐ Lateral Ligament laxity. ☐ Unstable Patella ☐ ↓ROM / ☐↓ Strength

LOWERS

Right Ankle/ Foot ☐ Swelling ☐ Deformity ___ Ø

☐ Ankle / ☐ Foot Tenderness→ ☐Medial ☐Lateral

☐ Decreased ROM / ☐↓ Strength

Left Ankle/ Foot ☐Swelling ☐Deformity ___ Ø

☐ Ankle / ☐ Foot Tenderness→ ☐Medial ☐Lateral

☐ Decreased ROM / ☐↓ Strength

SENSORY ___ Ø ☐↓Glove & Stocking

↓DERMATOMAL ☐R ☐L ↓AREA NO NERVE DERMATOME ☐R ☐L ↓NERVE ☐R ☐L

REFLEXES

___ BICEPS	R ↓ ↑ ∈	L ↓ ↑ ∈	___ PATELLA	R (↓) ↑ ∈	L ↓ ↑ ∈ Nl ___ Ø
___ TRICEPS	R ↓ ↑ ∈	L ↓ ↑ ∈	___ ANKLE	R ↓ ↑ ∈	L ↓ ↑ ∈
___ BRACHIORADIALIS	R ↓ ↑ ∈	L ↓ ↑ ∈	___ PLANTAR	R ⇓ ⇑ ∈	L ⇓ ⇑ ∈

∈ Absent ⇓ Downgoing ⇑ Upgoing

GAIT ☐ Antalgic Gait ☐ ↓Stance L R ☐ Abnormal, Describe.
☐ Straight cane ☐ Crutches ☐ Wheelchair

TONE ☐ Spastic ☐ Flaccid ___ Ø

PHYSICIAN MUST COMPLETE ALL:

Has this patient reached MMI? ☐ Yes ☒ No

Is CURRENTLY Working ☒ Yes ☐ No

Disabled from regular work duties? ☒ Yes ☐ No

If yes, Disability is ☐ Total ☒ Partial

☐ lift/carry/push/pull> _____ Lbs.

Other: ever.

COMPLETE 9 and 10 ONLY and ONLY AFTER MMI!!

This means your answer to #3 to the left, is YES.

9. FOR SCHEDULE LOSS PER WCB GUIDELINE:

_____ % loss of:

10. Can the patient do any type of work? ☐ Yes ☐ No

Describe Work Capacity as per US-DOT:

☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

☐ Precise guidelines need FCE

THIS WAS A PROLONGED VISIT, TIME: _____

GLADYS CARDENAS, M.D.

Dr Kenneth Fox

MD NAME AND SIGNATURE

CONTINUES IN PLAN, DX & THERAPY order sheets

IRM 111-10 2/2/2003

INITIAL VISIT WC, NF and PER[illegible]IAL INJURY
HISTORY AND PHYSICAL Page 1

NAME Walker, Livingston (WC) DATE 1/8/07

Current Age 51 Date of Accident 11/14/06 Occupation at time of accident: Operating Engineer

How did this accident occur? 51 yr old on the job 11-14-06, "concrete buggy jumped against wall, went to Westchester Med. Ctr, evaluated & released c/o "lump" in lower abdomen. LBP → R calf. Aleve & Tylenol helps a little.

B/B

For PMHx, PSHx, Meds, Social/Work, etc. Hx see Intake

Complaints:	Pain scale	Radiation	Numbness/ Paresthesia	Complaints:	Intensity	Complaints:	Intensity
Neck pain	( )			☐	( )	☐	( )
Low back pain	(8)	RLE	RLE	☐	( )	☐	( )
Upperback pain	( )			☐	( )	☐	( )

Pain Scale Mild 1-2-3 Moderate 4-5-6 Severe 7-8-9 Extremely severe 10

Severity Scale A: No prob B:Mild C: Mod D: severe E: Extr severe

PHYSICAL EXAMINATION: ♦ Check if Within Normal Limits Ø Check if not examined ☐ Mark for positive finding ↑ Circle if Increased ↓ Circle if Decreased

♦ GENERAL APPEARANCE: Alert OX3

☐ Disoriented to time space person ☐ distressed due to pain ☐ Antalgic mobility ☐ Requires assistance Sit↔ Stand ☐ Speech difficulty ☐ Decreased STM

♦ HEAD: ☐ FacialParesis→ R L Ø

☐ Swelling ☐ Tenderness ☐ CN Deficit→ R L

OTHER: BP: 140/85 HR: 64.

♦ CERVICAL SPINE: Ø

☐ Paraspinal Tenderness / ☐Spasm→ R L ☐ Bilateral

☐ Midline Tenderness ☐↓ ROM / ☐↓Strength ☐ Functional ROM / ☐ with Pain

Trigger/tender points in: ☐ Cervical paraspinal ☐ Trapezius ☐Rhomboid ☐ Other

♦ UPPER EXTREMITIES: Ø

☐Thenar Atrophy R L ☐ Hipothenar Atrophy R L ☐Intrinsics Atrophy R L

Shoulder Girth R ____ cm L ____ cm At axilla
Arm Girth R ____ cm L ____ cm 12 cm Proximal Lat. Epic.
Forearm R ____ cm L ____ cm 12 cm Distal Lat. Epic.

OTHER:

☐ Functional ROM in both U.E

Strength			
	↓ DELTOID	R	L
	↓ BICEPS	R	L
	↓ TRICEPS	R	L
	↓ WRIST EXTENSORS	R	L
	↓ GRIP	R	L

UPPERS

♦ Right Shoulder→ ☐ Swelling Ø

Tenderness→ ☐ Anterior ☐ Subacromial ☐ AC joint ☐ Diffuse

↓ ROM / ☐↓ Strength ☐ Painful arc

♦ Left Shoulder→ ☐ Swelling Ø

☐ Tenderness→ ☐ Anterior ☐ Subacromial ☐ AC joint ☐ Diffuse

☐↓ ROM / ☐↓ Strength ☐ Painful arc

♦ Right Elbow ☐ Swelling Ø

Tenderness→ ☐ Medial – ☐ Lateral – ☐ Radial head - ☐ Posterior - ☐ Diffuse

↓ ROM / ☐↓ Strength

♦ Left Elbow ☐ Swelling Ø

☐ Tenderness→ ☐ Medial – ☐ Lateral – ☐ Radial head - ☐ Posterior - ☐ Diffuse

☐↓ ROM / ☐↓ Strength

♦ Right Wrist→ ☐ Swelling ☐ Deformity Ø

Tenderness→ ☐ Medial – ☐ Lateral – ☐ Diffuse

↓ ROM / ☐↓ Strength ☐ Positive Finkelstein

♦ Left Wrist→ ☐ Swelling ☐ Deformity Ø

☐ Tenderness→ ☐ Medial – ☐ Lateral – ☐ Diffuse

☐↓ ROM / ☐↓ Strength ☐ Positive Finkelstein

♦ Right Hand Ø

Swelling/Tenderness ☐ MCP ☐ PIP ☐ DIP

Swelling/Tenderness → ☐ Dorsum of hand ☐ Palm ☐ Fingers

↓ Rom/ ☐↓ Strenght → ☐ Fingers: ☐ Grip

♦ Left Hand Ø

☐ Swelling/Tenderness ☐ MCP ☐ PIP ☐ DIP

☐ Swelling/Tenderness → ☐ Dorsum of hand ☐ Palm ☐ Fingers

☐↓ Rom/ ☐↓ Strenght → ☐ Fingers: ☐ Grip

EAST COAST PAIN MANAGEMENT, P.C.

1207 ROUTE 9, SUITE 4
WAPPINGERS FALLS NY 12590
(845) 297- 3200

354 DOWNING DRIVE
YORKTOWN HEIGHTS, NY 10598
(914) 248- 1612

200 SOUTH RIDGE STREET
RYE BROOK NY 10573
(914) 939- 9248

EVALUATION AND MANAGEMENT REPORT
WC NF & P. Injury

PATIENT: Walker, Livingston WC DATE: 1/29/07

Reason for this Evaluation: ☐ Emergency Visit ☒ Visit at patient's request.

☐ Scheduled visit after Initial Evaluation to review progress and Plan. ☐ Other, see Subjective.

SUBJECTIVE, patients concerns and or complaints:
Pt continues w/ LBP radiating to the RLE.
Records received: ER notes, Hx: pinned against a metal elevator door by a bus & carry up concrete. CXR + CT of

OBJECTIVE, Physical findings (if unchanged, state date) and work up results:
BP: 120/70 HR: 70 RR: 14
Abdomen + pelvis were WNL.
PE: A+O x 3, no distress
Rt LS tenderness, (+) RT SLR
DTR ↓ Rt patella
Sens WNL.

ASSESSMENT or diagnostic impression:
☐ See Diagnosis and therapy orders sheet

IF THIS IS A NEW CONDITION, MUST INDICATE IF IT IS: ☐CONSEQUENTIAL or ☐UNRELATED TO ACCIDENT ☐N/A

In case of Consequential Injury must explain mechanism:

Expected treatment and work-up for this Consequential injury: Therapy_____ times/week x_____ weeks.

Workup:

PLAN: See plan page attached.

3. Has MMI been reached? ☐Yes ☒No
7. Is CURRENTLY Working? ☒Yes ☐No
8. Disabled for regular work duties? ☒Yes ☐No
Disability is: ☐Total ☒Partial
Partial, Work Restrictions lift/carry/pull/push >

9. Impairment %:

ONLY After MMI has been reached: (if 3=YES)
10. Can patient do any type of work? ☐Yes ☐No
Describe Work Capacity per US-DOT: ☐Sedentary
☐Light ☐Medium ☐Heavy ☐Very Heavy

GLADYS CARDENAS, M.D.

PHYSICIANS NAME and SIGNATURE _____

FORM 113-1 2/3/2003

PT ORDERS AND Dx. WC/NF NAME: Walker, Livingston DATE: 4/2/07

PT 3 X week for 4 WEEKS

For reference WC units assigned per modality are in ( )

AQUATIC (Rye ONLY) PT 1 x/week Symptomatic ____ x ____ for ____ Internal use: 8 Units PT ⊘ MD DRY ⊘ AQUA

PASSIVE MODALITIES	Area#1	Area#2	Area3
☒ 97010 Hot Packs(2)	LS		
☒ 97032 Electrical Stim.(2.5)	LS		
☒ 97035 Ultrasound(2.5)	LS		
☐ 97018 Paraffin Bath(2.5)			
☐ 97124 Massage (2.5)			

Passive used for: ☐ Inflammation/edema ☐ Spasm ☐ Soften scars ☐ Prepare for exercise ☐ ↓Joint Pain ☐ ↓Arthritic condition ☐ ↓Joint Pain

☐ Progress PT as tolerated
☐ PRN modalities
☐ Pre-post PT Ice PRN

97140 Manual Therapy

☒ Soft Tissue Mobilization (MFR)(4)
☐ Joint Mobilization(4)
☐ Manipulation(4) ☐ Manual Traction (4)

Manual used to:
☒ Shortened tissue
☐ ↑ Fluid exchange
☐ Mobilize tissue w/edema
☒ ↑Mobility

97530 Functional Activities

☐ Trunk activities to ↑Bending
☐ UE / LE activities to ↑ Carrying
☐ UE / LE activities to ↑ Reaching
☐ UE activities to ↑Object Manipulation
☐ Activities to improve transfers
☐ Other:
☐ Activities to promote safe ambulation
☐ Activities to improve stair negotiation
☐ Other activities to improve function:
☐ Cervical activities to improve head turning
☐ Activities to improve bed mobility

(2.5 per 15 minutes)

97113 AQUATIC

RYE ONLY PLEASE !!!
☐ Core exercise ☐ No Jets
☐ UE exercise ☐ Walk only ☐ Progressive Jets
☐ LE exercise ☐ Progress to run

Used to : ☐ ↑ ROM ☐ ↑ Strength ☐ ↑ Endurance

97112 Neuro-Muscular Re-Education

☐ Cervical Stabilization
☒ Trunk Stabilization
☐ Upp. Extr. Re-Education
☐ Low. Extr. Re-Education
☐ Proprioceptive Neuromuscularfacilitation
☐ Balance
☐ Coordination
☐ Desensitization

(3.5 per 15 minutes)

Used to:
☐ ↑Kinesthetic Sense
☐ ↑CS Posture
☐ ↑TS Posture
☒ ↑LS Posture
☐ ↑Proprioception
☐ ↑Standing Balance
☐ ↑Gross Coordination
☐ ↑Fine Coordination
☐ ↑Muscle Tone
☐ ↓Muscle Tone

TAPING

29240 ☐Shoulder 29260 ☐Elbow ☐Wrist 29280 ☐Hand/Finger 29220 ☐Low back
29520 ☐Hip 29530 ☐Knee 29540 ☐Ankle (0.2-0.3 Surgical units)

Diagnosis	EM	PT	Procedure
Lumbo sacral s/s			
(R) Lumbosacral rad			

For billing purpose, check if diagnosis is related to PT program and/or EM visit and/or procedure ordered (specify procedure)

GLADYS CARDENAS, M.D.

PHYSICIANS NAME and SIGNATURE

97110 Therapeutic Exercise

THERAPEUTIC EXERCISE

ROM exercises
☐ AROM
☐ AAROM
☐ PROM

STRETCH exercises
☒ Active (B) LE
☒ Assistive
☒ Prolonged static

NON RESISTED strengthening
☐ CS ☐ TS/LS
☐ UE ☐ LE

ISOMETRIC exercises
☐ CS
☐ TS/LS
☐ UE
☐ LE

ABDOMINAL strengthening
☒ Pelvic Tilt
☒ Crunches

HAND exercises
☐ ROM
☐ Strengthening

ISOTONIC strengthening
☐ Thera-band
☐ Dumb-bells
☐ Ankle Weights

CIRCUIT ☐ Full Circuit
☐ Cable Column
☒ Back Extension
☒ Resisted Crunch
☐ Multi Hip
☐ Leg Press
☐ Leg Curl
☐ Leg Extension

CARDIOVASCULAR
☐ Bike ☐ Tread-Mill ☐ UBE ☐ Warm-up/Cool-down ☐ Strength extremities
☐ Cardiovascular work LIMIT to____ % of Max HR for Age (=220 – age / %)

(3.5 per 15 min)

97537 Reintegration

☐ Community ☐ Work Specific Function: (3)

97535 Self Care

Specific Need: ☐ HEP ☐ Maintenance ☐ other: (3)
(Max 6 sessions) & follow : x weeks/months

PT SHORT TERM GOALS
☐ ↑Functional Performance
☐ ↑ROM
☐ ↑Strength
☐ ↓Pain
☐ Symptomatic benefit
☒ Per PT evaluation

PT LONG TERM GOALS
☐ Max Function
☐ Max ROM
☐ Max Strength
☐ Pain level 0
☐ Symptomatic benefit
☒ Per PT evaluation

Form 301-01 WC NF PT Orders and Dx revised 2/13/2006

☐ CHECK BP & PULSE PRE-POST THERAPY ☐ CHECK BODY WEIGHT ____ X per Week. ☐ FALL PRECAUTIONS
☐ CARDIAC PRECAUTIONS ☐ HIP PRECAUTIONS ☐ SEIZURE PRECAUTIONS

ROM/MMT/PT evaluation: ☐ PT Evaluation ☐ ROM MMT Baseline ☒ ROM MMT prior to FU ☐ FCE

ROM ☐ CS ☒ Trunk Shoulder ☐R - ☐L Elbow ☐R - ☐L Wrist ☐R - ☐L Hip ☐R - ☐L Knee ☐R - ☐L Ankle ☐R - ☐L Hand ☐R ☐L ☐R 1 2 3 4 5 ☐L 1 2 3 4 5
MMT ☐ CS/UE ☒ Trunk /LE Shoulder ☐R - ☐L Elbow ☐R - ☐L Wrist ☐R - ☐L Hip ☐R - ☐L Knee ☐R - ☐L Ankle ☐R - ☐L Hand ☐R ☐L ☐R 1 2 3 4 5 ☐L 1 2 3 4 5
Grip ☐R - ☐L Pinch ☐R - ☐L Toe ROM ☐R 1 2 3 4 5 ☐L 1 2 3 4 5 ↑Digits Only↑

PLAN PAGE

PATIENT: Walker, Livingston DATE: 4/2/07

PT: 3 X week for 4 WEEKS ___ Water (Rye only) SYMPTOMATIC (WC/C ONLY): ___ X ___ for ___

☐Continue Physical Therapy ☐PT evaluation ___ PT visits for HEP instruction (max 6) ☐HEP

☐Discontinue PT ☐Hold PT ☐PT close to home/IC OK'd facility ☐FCE followed by EM w/FCE ☐ADL & Functional Evaluation

See PT Order and Diagnosis page for details of PT orders, PT goals and precautions.

INJECTIONS: (May need pre-approval)

☒Trigger Point C5	Series of # 4	Start ☒ASAP	Interval 1 weeks
☐Tendon/lig/Ganglion/Fascia ☐ Medicare Carpal/Tarsal	Series of # ___	Start ☐ ASAP	Interval ___ weeks
☐Peripheral Nerve	Series of # ___	Start ☐ ASAP	Interval ___ weeks
☐Joint/Bursa	Series of # ___	Start ☐ ASAP	Interval ___ weeks
☐*Paravertebral (Transforaminal)	Series of # ___	Start ☐ ASAP	Interval ___ weeks (2 min)
☐*Facet Block, Level	Series of # ___	Start ☐ ASAP	Interval ___ weeks (2 min)
☐*Epidural/Caudal, Level	Series of # ___	Start ☐ ASAP	Interval ___ weeks (2 min)

* Necessity: ☐Painful radiculopathy ☐ Facet Syndrome ☐Pain management ☐Inflammatory arthritis ☐Painful neuropathy ☐Diagnostic Block

EMG & NCV: (May need pre-approval) ☐ UPPER EXTREMITIES ☐ LOWER EXTREMITIES ☐ OTHER:

To evaluate for: ☐Radiculopathy ☐CTS ☐Myopathy ☐Neuropathy ☐Check for radiculopathy prior to Facet Block ☐Other:

RADIOLOGIC WORK UP: (May need pre-approval)

MRI of: R/O ☐ HNP ☐ Int Derange ☐ Other

X-Ray of: R/O ☐ Fracture ☐ O.A. ☐ Bone pathology

Other: R/O

LAB WORK UP: ☐ CBC ☐ Sed Rate ☐ EKG baseline ☐ UA ☐ Other:

☐ Blood Chem ☐ Arthritis profile ☐ LFT ☐ Urine Toxicology ☐ Other:

ORTHOSES & EQUIPMENT

☐ TENS UNIT ☐ Insoles ☐ Cock-Up Splint ☐ Wrist Brace
☐ C-Collar ☐ Cane ☐ Knee Brace ☐ Elbow cuff
☐ Ls Orthosis ☐ Walker ☐ Ankle Brace ☐ Electrical Stimulator

MEDS STRENGTH DOSE	Rx #	X
☐RELAFEN ☐NAPROSYN		
☐ULTRAM ☐CELEBREX		
☒SOMA ☐FLEXERIL ☐SKELAXIN 5mg q.H.S.	30	2
TYLENOL ☐#3 ☐#4		
☐HYDROCODONE ☐VICODIN		
☐COMBUNOX ☐PERCOCET		
☐ELAVIL ☐DESIPRAMINE		
☐CELEXA ☐ZOLOFT		
☐LIDOCAINE PATCH		
☐NEURONTIN ☐LYRICA		
☐ULTRACET		

MEDS STRENGTH DOSE	Rx#	X
☐KADIAN		
☐METHADONE		
☐OXYCONTIN		
☐OXYCODONE ☐OXY-IR		
☐FENTANYL PATCH		
☐MSIR ☐MSCONTIN		

☐ SIGN PAIN MANAGEMENT AGREEMENT ☐ Has Meds

CONSULTATION: Dr: Specialty: (May need pre-approval)

☐ EM ___ ☐Two weeks EM ☒ EM following PT course(w/PTeval/ADL/ROM, if applies)

☐ EM ASAP for ___ ☐With records ___

☐ EM for Pain Management/Meds in ___ ☐Schedule QV for Meds every ___ x ___

☐ Continue visits as previously planned ☐Return PRN ☐Discharge

☐ INSTRUCT the patient to fill a RESPONSE TO PAIN MEDICATION "take home" chart ___ days prior to the next visit.

Medication to be charted: 1- 2- 3- 4-

It is my professional opinion that the above plan is medically necessary to provide appropriate care for this patient

GLADYS CARRENAS, M.D.

DR. NAME AND SIGNATURE

FOLLOW-UP EVALUAT N

NAME Walker, Livi JSTM WC DATE: 4/2/07

WC NF P. INJURY

Complaints:	Pain scale	Radiation	Numbness/ Paresthesia	Improving?
Neck pain	( )			Yes No
Low back pain	(3-7)	Rt E	Some	Yes No
Upperback pain	( )			Yes No

Pain Scale Mild 1-2-3 Moderate 4-5-6 Severe 7-8-9 Extremely severe 10

Complaints:	Pain	Severity	Improving?
☐	( )	( )	Yes No
☐	( )	( )	Yes No
☐	( )	( )	Yes No

Severity Scale A: No prob B:Mild C: Mod. D: severe E: Extr severe

PHYSICAL EXAMINATION
☒ A&Ox3 ☐ Antalgic mobility
☒ No distress ☐ Distress due to pain

HEAD/FACE: ☒ WNL
☐ Swelling
☐ Tenderness

CERVICAL SPINE ☐ WFL
☐ Tenderness ☐ Spasm
☐ Painful ROM

ROM ☐ Improving ☐ Not Improving ☐ Some imp.
Strength: ☐ Improving ☐ Not Improving ☐ Some Imp
Trigger/tender points in: ☐ Cervical paraspinal
☐ Trapezius ☐ Rhomboid
☐ Other

OTHER: BP: 144/98 HR: 74 RR: 18
Waiting approval for EMG. PT helping - pain has ↓, but still severe with certain movement.

THORACIC SPINE ☐ WFL
☐ Tenderness ☐ Spasm
☐ Painful ROM

Trigger/tender points in: ☐ Thoracic paraspinal
☐ Serratus ☐ Latissimus
☐ Other

LUMBOSACRAL SPINE ☐ WFL
☒ Tenderness RT ☒ Spasm RT
☒ Painful ROM

ROM ☒ Improving ☐ Not Improving ☐ Some imp.
Strength: ☐ Improving ☐ Not Improving ☐ Some imp.
Trigger/tender points in: ☒ L-S paraspinal
☒ Q. Lumborum ☒ Gluteus (R)
☐ Other

Right Shoulder ☐ WFL ☐ Swelling
Tenderness: ☐ Anterior ☐ Subacromial
☐ Diffuse ☐ ACJoint ☐ Painful arc
☐ Painful ROM

ROM ☐ Improving ☐ Not Improving ☐ Some imp.
Strength: ☐ Improving ☐ Not Improving ☐ Some imp.

Left Shoulder ☐ WFL ☐ Swelling
Tenderness: ☐ Anterior ☐ Subacromial
☐ Diffuse ☐ ACJoint ☐ Painful arc
☐ Painful ROM

ROM ☐ Improving ☐ Not Improving ☐ Some imp.
Strength ☐ Improving ☐ Not Improving ☐ Some imp.

SLR Positive (R) L ☐ Bilateral ☐ Negative

DTR's ☐ Normal symetric all 4 extremities
∈= absent ↓=decreased ↑=increased

Right				Left		
↓	↑	∈	Biceps	↓	↑	∈
↓	↑	∈	Triceps	↓	↑	∈
↓	↑	∈	Brach-rad	↓	↑	∈
(↓)	↑	∈	Patella	↓	↑	∈
↓	↑	∈	Achilles	↓	↑	∈

☐ All others are WNL

Right Elbow ☐ WFL ☐ Swelling
Tenderness: ☐ Medial ☐ Lateral
☐ Painful ROM

ROM ☐ Improving ☐ Not Improving ☐ Some imp.
Strength: ☐ Improving ☐ Not Improving ☐ Some Imp.

Left Elbow ☐ WFL ☐ Swelling
Tenderness: ☐ Medial ☐ Lateral
☐ Painful ROM

ROM ☐ Improving ☐ Not Improving ☐ Some Imp.
Strength ☐ Improving ☐ Not Improving ☐ Some Imp.

GAIT ☒ WNL
☐ Antalgic Gait ☐ ↓Stance L R
☐ Straight cane ☐ Crutches
☐ Wheelchair

Right Wrist/Hand: ☐ WFL ☐ Painful ROM
☐ Swelling ☐ Tenderness:

☐ Positive Phalen ☐ Positive Tinel
ROM ☐ Improving ☐ Not Improving ☐ Some imp.
Strength ☐ Improving ☐ Not Improving ☐ Some Imp

Left Wrist ☐ WFL ☐ Painful ROM
☐ Swelling ☐ Tenderness:

☐ Positive Phalen ☐ Positive Tinel
ROM ☐ Improving ☐ Not Improving ☐ Some imp.
Strength ☐ Improving ☐ Not Improving ☐ Some Imp

Sensation: ☒ WNL
☐ ↑ In:
☐ ↓ In:
☐ ↓ In glove and stocking

Right Hip ☐ WFL
☐ Tenderness ☐ Painful ROM

ROM ☐ Improving ☐ Not Improving ☐ Some imp.
Strength ☐ Improving ☐ Not Improving ☐ Some Imp.

Left Hip ☐ WFL
☐ Tenderness ☐ Painful ROM

ROM ☐ Improving ☐ Not Improving ☐ Some Imp.
Strength ☐ Improving ☐ Not Improving ☐ Some Imp.

OTHER:

THIS WAS A PROLONGED VISIT, TIME:

Right Knee ☐ WFL ☐ Painful ROM
☐ Effusion ☐ Swelling
☐ Joint Line tenderness M L ☐ McMURray
☐ Positive Drawer A P ☐ Pivot Shift
☐ Collateral Ligament laxity M L

ROM ☐ Improving ☐ Not Improving ☐ Some Imp.
Strength ☐ Improving ☐ Not Improving ☐ Some Imp.

Left Knee ☐ WFL ☐ Painful ROM
☐ Effusion ☐ Swelling
☐ Joint Line tenderness M L ☐ McMURray
☐ Positive Drawer A P ☐ Pivot Shift
☐ Collateral Ligament laxity M L

ROM ☐ Improving ☐ Not Improving ☐ Some Imp.
Strength ☐ Improving ☐ Not Improving ☐ Some Imp.

3. Has MMI been reached? ☐ Yes ☒ No
7. Is CURRENTLY Working? ☒ Yes ☐ No
8. Disabled for regular work duties? ☐ Yes ☐ No
Disability is: ☐ Total ☐ Partial
If Partial, Work Restrictions lift/carry/pull/push: ____
9. Impairment %:

Right Ankle/ Foot ☐ WFL
☐ Swelling ☐ Deformity
☐ Tenderness
☐ Painful ROM
ROM ☐ Improving ☐ Not Improving ☐ Some Imp.
Strength ☐ Improving ☐ Not Improving ☐ Some Imp.

Left Ankle/ Foot ☐ WFL
☐ Swelling ☐ Deformity
☐ Tenderness
☐ Painful ROM
ROM ☐ Improving ☐ Not Improving ☐ Some Imp.
Strength ☐ Improving ☐ Not Improving ☐ Some Imp.

ONLY After MMI has been reached: (if 3=YES
10. Can patient do any type of work? ☐ Yes ☐ No
Describe Work Capablity per US-DOT: ☐ Sedentary
☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

MD NAME AND SIGNATURE GLADYS GARDENAS, M.D.

East Coast
Pain Management, PC

Pain Management, Rehabilitation, Physical Therapy,
Chiropractic & Acupuncture

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PLAN PAGE

PATIENT: Walker, Livingston DATE: 1/29/07

PT: 3 X week for 4 WEEKS 1 Water (Rye only) SYMPTOMATIC (WC/C ONLY): _____ X _____ for _____

☒Continue Physical Therapy ☐PT evaluation ____ PT visits for HEP Instruction (max 6) ☐HEP

☐Discontinue PT ☐Hold PT ☐PT close to home/IC OK'd facility ☐FCE followed by EM w/FCE ☐ADL & Functional Evaluation

See PT Order and Diagnosis page for details of PT orders, PT goals and precautions.

INJECTIONS: (May need pre-approval)

☐Trigger Point_____	Series of #____	Start_____ ☐ASAP	Interval____ weeks
☐Tendon/lig/Ganglion/Fascia_____ ☐ Medicare Carpal/Tarsal	Series of #____	Start_____ ☐ASAP	Interval____ weeks
☐Peripheral Nerve _____	Series of #____	Start_____ ☐ASAP	Interval____ weeks
☐Joint/Bursa _____	Series of #____	Start_____ ☐ASAP	Interval____ weeks
☐*Paravertebral (Transforaminal)_____	Series of #____	Start_____ ☐ASAP	Interval____ weeks (2 min)
☐*Facet Block, Level _____	Series of #____	Start_____ ☐ASAP	Interval____ weeks (2 min)
☐*Epidural/Caudal, Level _____	Series of #____	Start_____ ☐ASAP	Interval____ weeks (2 min)

* Necessity: ☐Painful radiculopathy ☐ Facet Syndrome ☐Pain management ☐Inflammatory arthritis ☐Painful neuropathy ☐Diagnostic Block

EMG & NCV: (May need pre-approval) ☐ UPPER EXTREMITIES ☒ LOWER EXTREMITIES ☐ OTHER:

To evaluate for: ☐Radiculopathy ☐CTS ☐Myopathy ☐Neuropathy ☒Check for radiculopathy prior to Facet Block ☐Other:

RADIOLOGIC WORK UP: (May need pre-approval)

MRI of: ☒LS

R/O ☐HNP ☐ Int. Derange ☐ Other

X-Ray of: LS w/obl

R/O ☐ Fracture ☐ O.A. ☐ Bone pathology

Other:

R/O

LAB WORK UP: ☐ CBC ☐ Sed Rate ☐ EKG baseline ☐ UA ☐ Other:

☐ Blood Chem ☐ Arthritis profile ☐ LFT ☐ Urine Toxicology ☐ Other:

ORTHOSES & EQUIPMENT

☐ TENS UNIT	☐ Insoles	☐ Cock-Up Splint	☐ Wrist Brace
☐ C-Collar	☐ Cane	☐ Knee Brace	☐ Elbow cuff
☐ Ls Orthosis	☐ Walker	☐ Ankle Brace	☐ Electrical Stimulator

MEDS STRENGTH DOSE	Rx #	X
☐RELAFEN ☐NAPROSYN		
☐ULTRAM ☐CELEBREX		
☐SOMA ☐FLEXERIL ☐SKELAXIN		
TYLENOL ☐#3 ☐#4		
☐HYDROCODONE ☐VICODIN		
☐COMBUNOX ☐PERCOCET		
☐ELAVIL ☐DESIPRAMINE		
☐CELEXA ☐ZOLOFT		
☐LIDOCAINE PATCH		
☐NEURONTIN ☐LYRICA		
☐ULTRACET		

MEDS STRENGTH DOSE	Rx#	X
☐KADIAN		
☐METHADONE		
☐OXYCONTIN		
☐OXYCODONE ☐OXY-IR		
☐FENTANYL PATCH		
☐MSIR ☐MSCONTIN		
☐ SIGN PAIN MANAGEMENT AGREEMENT ☐ Has Meds		

CONSULTATION: Dr: Specialty: (May need pre-approval)

☐ EM _____ ☐Two weeks EM ☐ EM following PT course(w/PTeval/ADL/ROM, if applies)

☐ EM ASAP for _____ ☒With records MRI WCM received

☐ EM for Pain Management/Meds in _____ ☐Schedule QV for Meds every _____ x _____

☐ Continue visits as previously planned ☐Return PRN ☐Discharge

☐ INSTRUCT the patient to fill a RESPONSE TO PAIN MEDICATION "take home" chart _____ days prior to the next visit.

Medication to be charted: 1- 2- 3- 4-

It is my professional opinion that the above plan is medically necessary to provide appropriate care for this patient.

GLADYS CARDENAS, M.D.

DR. NAME AND SIGNATURE

PT ORDERS AND Dx. WC/NF N. E: Walker, Livingston **DATE:** 11/10/07

PT 3 X week for 4 WEEKS — For reference WC units assigned per modality are in ( )

AQUATIC (Rye ONLY) PT _____x/week — Symptomatic _____ x _____ for _____ — Internal use: 8 Units — PT ⊘ MD DRY ⊘ AQUA

PASSIVE MODALITIES	Area#1	Area#2	Area3
☑ 97010 Hot Packs(2)	5		
☑ 97032 Electrical Stim (2.5)	5		
☑ 97035 Ultrasound(2.5)	5		
☐ 97018 Paraffin Bath(2.5)			
☐ 97124 Massage (2.5)			

Passive used to: ☐↓Inflammation/edema ☐↓Spasm ☐Soften scars ☐Prepare for exercise ☐↓Joint Pain ☐↓Arthritic condition ☐↓Joint Pain

☐ Progress PT as tolerated
☐ PRN modalities
☐ Pre-post PT Ice PRN

97140 Manual Therapy

☑ Soft Tissue Mobilization (MFR)(4)
☐ Joint Mobilization(4)
☐ Manipulation(4) ☐ Manual Traction (4)

Manual used to: ☐↓Shortened tissue ☐↑ Fluid exchange ☐ Mobilize tissue w/edema ☑↑Mobility

97530 Functional Activities

☐ Trunk activities to ↑Bending
☐ UE / LE activities to ↑ Carrying
☐ UE / LE activities to ↑ Reaching
☐ UE activities to ↑Object Manipulation
☐ Activities to improve transfers
☐ Other:
☐ Activities to promote safe ambulation
☐ Activities to improve stair negotiation
☐ Other activities to improve function:
☐ Cervical activities to improve head turning
☐ Activities to improve bed mobility
(2.5 per 15 minutes)

97113 AQUATIC

RYE ONLY PLEASE !!! ☐ UE exercise ☐ LE exercise ☐ Core exercise ☐ Walk only ☐ Progress to run ☐ No Jets ☐ Progressive Jets

Used to : ☐ ↑ ROM ☐ ↑ Strength ☐ ↑ Endurance

97112 Neuro-Muscular Re-Education

☐ Cervical Stabilization
☑ Trunk Stabilization
☐ Upp. Extr. Re-Education
☐ Low. Extr. Re-Education
☐ Proprioceptive Neuromuscularfacilitation
☐ Balance
☐ Coordination
☐ Desensitization
(3.5 per 15 minutes)

Used to:
☐ ↑Kinesthetic Sense
☐ ↑CS Posture
☐ ↑TS Posture
☑ ↑LS Posture
☐ ↑Proprioception
☐ ↑Standing Balance
☐ ↑Gross Coordination
☐ ↑Fine Coordination
☐ ↑Muscle Tone
☐ ↓Muscle Tone

TAPING

29240 ☐Shoulder 29260 ☐Elbow ☐Wrist 29280 ☐Hand/Finger 29220 ☐Low back
29520 ☐Hip 29530 ☐Knee 29540 ☐Ankle (0.2-0.3 Surgical units)

Diagnosis	EM	PT	Procedure
Lumbosacral s/s	✓	✓	
(R) lumbosacral rad	✓	✓	

For billing purpose, check if diagnosis is related to PT program and/or M visit and/or procedure ordered (specify procedure).

GLADYS CARDENAS, M.D.
PHYSICIANS NAME and SIGNATURE

97110 Therapeutic Exercise

THERAPEUTIC EXERCISE

ROM exercises
☐ AROM
☐ AAROM
☐ PROM

STRETCH exercises
☐ Active
☐ Assistive
☐ Prolonged static

NON RESISTED strengthening
☐ CS ☐ TS/LS
☐ UE ☐ LE

ISOMETRIC exercises
☐ CS
☐ TS/LS
☐ UE
☐ LE

ABDOMINAL strengthening
☐ Pelvic Tilt
☐ Crunches

HAND exercises
☐ ROM
☐ Strengthening

ISOTONIC strengthening
☐ Thera-band
☐ Dumb-bells
☐ Ankle Weights

CIRCUIT ☐ Full Circuit
☐ Cable Column
☐ Back Extension
☐ Resisted Crunch
☐ Multi Hip
☐ Leg Press
☐ Leg Curl
☐ Leg Extension

CARDIOVASCULAR
☐ Bike ☐ Tread-Mill ☐ UBE ☐ Warm-up/Cool-down ☐ Strength extremities
☐ Cardiovascular work LIMIT to_____ % of Max HR for Age (=220 – age / %)
(3.5 per 15 min)

97537 Reintegration
☐ Community ☐ Work Specific Function: (3)

97535 Self Care
Specific Need: ☐ HEP ☐ Maintenance ☐ other: (3)
(Max 6 sessions) & follow : x weeks/months

T SHORT TERM GOALS
- ↑Functional Performance
- ↑ROM
- ↑Strength
- ↓Pain
- Symptomatic benefit
- Per PT evaluation

PT LONG TERM GOALS
- ☐ Max Function
- ☐ Max ROM
- ☐ Max Strength
- ☐ Pain level 0
- ☐ Symptomatic benefit
- ☐ Per PT evaluation

Form 301-01 WC NF PT Orders and Dx revised 2/13/2006

☐ CHECK BP & PULSE PRE-POST THERAPY ☐ CHECK BODY WEIGHT ____ X per Week. ☐ FALL PRECAUTIONS
☐ CARDIAC PRECAUTIONS ☐ HIP PRECAUTIONS ☐ SEIZURE PRECAUTIONS

ROM/MMT/PT evaluation: ☐ PT Evaluation ☐ ROM MMT Baseline ☑ ROM MMT prior to FU ☐ FCE

ROM ☐ CS ☑ Trunk Shoulder ☐R - ☐L Elbow ☐R - ☐L Wrist ☐R - ☐L Hip ☐R - ☐L Knee ☐R - ☐L Ankle ☐R - ☐L Hand ☐R ☐L ☐R 1 2 3 4 5 ☐L 1 2 3 4 5

MMT ☐ CS/UE ☑ Trunk /LE Shoulder ☐R - ☐L Elbow ☐R - ☐L Wrist ☐R - ☐L Hip ☐R - ☐L Knee ☐R - ☐L Ankle ☐R - ☐L Hand ☐R ☐L ☐R 1 2 3 4 5 ☐L 1 2 3 4 5

Grip ☐R - ☐L Pinch ☐R - ☐L Toe ROM ☐R 1 2 3 4 5 ☐L 1 2 3 4 5 †Digits Only†

PLAN PAGE

PATIENT: Walker, Livingston DATE: 3/5/07

PT: ___ X week for ___ WEEKS ___ Water (Rye only) SYMPTOMATIC (WC/C ONLY): ___ X ___ for ___

☐Continue Physical Therapy ☐PT evaluation ___ PT visits for HEP instruction (max 6) ☐HEP

☐Discontinue PT ☐Hold PT ☐PT close to home/IC OK'd facility ☐FCE followed by EM w/FCE ☐ADL & Functional Evaluation

See PT Order and Diagnosis page for details of PT orders, PT goals and precautions

INJECTIONS: (May need pre-approval)

☐Trigger Point ___	Series of # ___	Start ___ A SAP	Interval ___ weeks	
☐Tendon/lig/Ganglion/Fascia ___ Medicare Carpal/Tarsal	Series of # ___	Start ___ A SAP	Interval ___ weeks	
☐Peripheral Nerve ___	Series of # ___	Start ___ ASAP	Interval ___ weeks	
☐Joint/Bursa ___	Series of # ___	Start ___ ASAP	Interval ___ weeks	
☐*Paravertebral (Transforaminal) ___	Series of # ___	Start ___ ASAP	Interval ___ weeks (2 min)	
☐*Facet Block, Level ___	Series of # ___	Start ___ ASAP	Interval ___ weeks (2 min)	
☐*Epidural/Caudal, Level ___	Series of # ___	Start ___ ASAP	Interval ___ weeks (2 min)	

* Necessity: ☐Painful radiculopathy Facet Syndrome ☐Pain management Inflammatory arthritis Painful neuropathy ☐Diagnostic Block

EMG & NCV: (May need pre-approval) UPPER EXTREMITIES LOWER EXTREMITIES OTHER:

To evaluate for: ☐Radiculopathy ☐CTS ☐Myopathy ☐Neuropathy ☐Check for radiculopathy prior to Facet Block ☐Other:

RADIOLOGIC WORK UP: (May need pre-approval)

MRI of:	X-Ray of:	Other:
R/O ☐HNP ☐Int Derange Other	R/O ☐Fracture ☐O.A. ☐Bone pathology	R/O

LAB WORK UP: ☐CBC ☐Sed Rate ☐EKG baseline ☐UA ☐Other:

☐Blood Chem ☐Arthritis profile ☐LFT ☐Urine Toxicology ☐Other:

ORTHOSES & EQUIPMENT

☐TENS UNIT	☐Insoles	☐Cock-Up Splint	☐Wrist Brace	☐
☐C-Collar	☐Cane	☐Knee Brace	☐Elbow cuff	
☐Ls Orthosis	☐Walker	☐Ankle Brace	☐Electrical Stimulator	

MEDS	STRENGTH	DOSE	Rx #	X
☐RELAFEN ☐NAPROSYN				
☐ULTRAM ☐CELEBREX				
☐SOMA ☐FLEXERIL ☐SKELAXIN				
TYLENOL ☐#3 ☐#4				
☐HYDROCODONE ☐VICODIN				
☐COMBUNOX ☐PERCOCET				
☐ELAVIL ☐DESIPRAMINE				
☐CELEXA ☐ZOLOFT				
☐LIDOCAINE PATCH				
☐NEURONTIN ☐LYRICA				
☐ULTRACET				

MEDS	STRENGTH	DOSE	Rx#	X
☐KADIAN				
☐METHADONE				
☐OXYCONTIN				
☐OXYCODONE ☐OXY-IR				
☐FENTANYL PATCH				
☐MSIR ☐MSCONTIN				

☐ SIGN PAIN MANAGEMENT AGREEMENT ☐ Has Meds

CONSULTATION: Dr: Specialty: (May need pre-approval)

☐ EM ___ ☐Two weeks EM ☐EM following PT course(w/PTeval/ADL/ROM, if applies)

☐ EM ASAP for ___ ☐With records ___

☐ EM for Pain Management/Meds in ___ ☐Schedule QV for Meds every ___ x ___

☐ Continue visits as previously planned ☐Return PRN ☐Discharge

☐ INSTRUCT the patient to fill a RESPONSE TO PAIN MEDICATION "take home" chart ___ days prior to the next visit.

Medication to be charted: 1- 2- 3- 4-

It is my professional opinion that the above plan is medically necessary to provide appropriate care for this patient.

GLADYS CARDENAS, M.D.

DR. NAME AND SIGNATURE

LS and LOWER BODY PAIN CHART-VAS

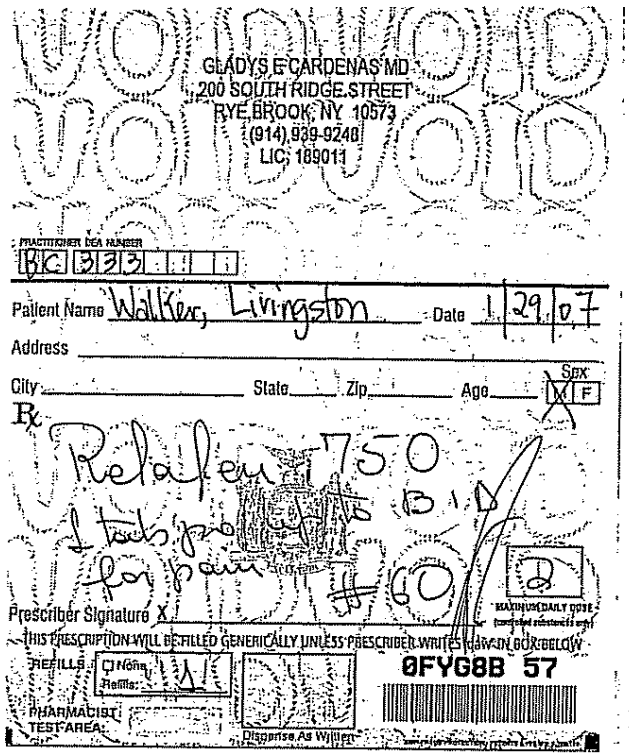
LAST NAME: Walker
FIRST NAME: Livingston
CASE: WC

↓DATE	1/8/07	1/10/07	1/12/07	1/17/07	1/19/07	1/24/07	FU 1/29/07	2/2/07	EM 2/5/07	2/28/07	FU 4/2/07	PT 9/4/07
➢LOW BACK PAIN	8	8	8	6	5	5	5	5	4/5	2	3	3
➢*Pain travels down the Right leg* w/ motion	8	8	8	6	6	6	5	5	4/5	1	2	3
➢*Pain travels down the Left Leg*	X						0	0	0	0	0	0
➢*Tingling or numbness in the Right leg* (upper)	8	8	8	6	6	6	5	5	5/6	1	2	2
➢*Tingling or numbness in the Left leg*	X						0	0	0	0	0	0
➢*Right foot numbness or tingling*	X						0	0	0	0	0	0
➢*Left foot numbness or tingling*	X						0	0	0	0	0	0
Right HIP THIGH pain												
Left HIP THIGH pain												
Right KNEE LEG pain												
Left KNEE LEG pain												
Right ANKLE FOOT pain												
Left ANKLE FOOT pain												

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26

NO PAIN or NO PROBLEM — SEVERE PAIN or SEVERE PROBLEM

0 1 2 3 4 5 6 7 8 9 10



GLADYS E CARDENAS MD
200 SOUTH RIDGE STREET
RYE BROOK, NY 10573
(914) 939-9248
LIC: 189011

PRACTITIONER DEA NUMBER
BC 3313 [illegible]

Patient Name Walker, Livingston Date 1/29/07

Address

City State Zip Age Sex: M F

Rx
Relafen 750
1 tab po bid
for pain #60

Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES DAW IN BOX BELOW

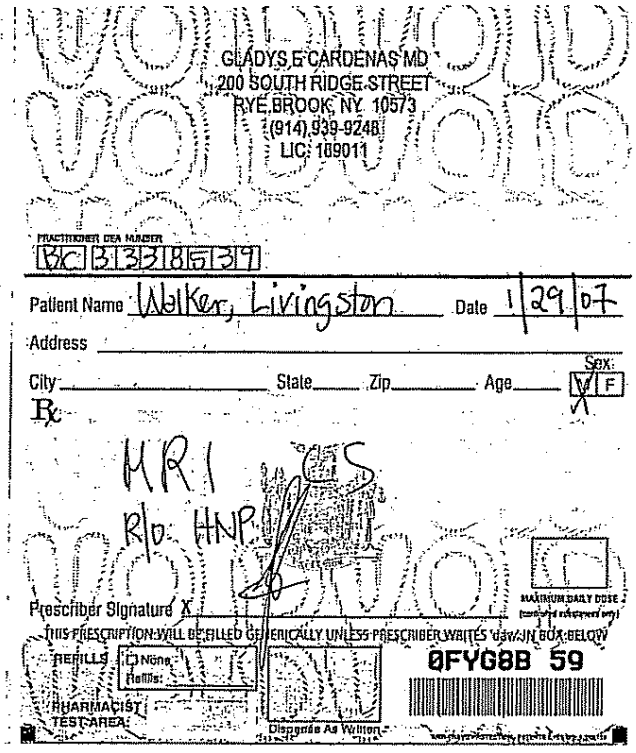
REFILLS None Refills: 1

PHARMACIST TEST AREA:

Dispense As Written

MAXIMUM DAILY DOSE

0FYG8B 57



GLADYS E CARDENAS MD
200 SOUTH RIDGE STREET
RYE BROOK, NY 10573
(914) 939-9248
LIC: 189011

PRACTITIONER DEA NUMBER
BC 3133185137

Patient Name Walker, Livingston Date 1/29/07

Address

City State Zip Age Sex: M F

Rx
MRI CS
R/o HNP

Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES DAW IN BOX BELOW

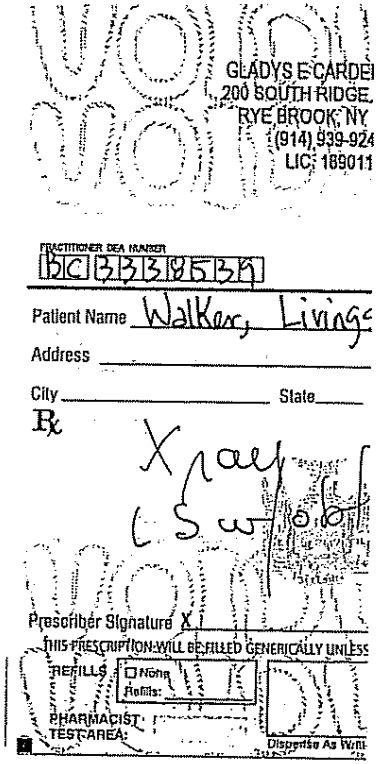
REFILLS None Refills:

PHARMACIST TEST AREA:

Dispense As Written

MAXIMUM DAILY DOSE

0FYG8B 59



GLADYS E CARDEI
200 SOUTH RIDGE
RYE BROOK, NY
(914) 939-924
LIC: 189011

PRACTITIONER DEA NUMBER
BC 3313185137

Patient Name Walker, Living 1/29/07

Address

City State

Rx
Xray
LS3 80

Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS

REFILLS None Refills:

PHARMACIST TEST AREA:

Dispense As Writ

Gladys Cardenas MD
200 South Ridge St.
Rye Brook, NY 10573

April 11, 2007

ppointment List for Livingston Walker, #3133 Case#1
ate range: 04/11/2007 -> 05/09/2007

ednesday April 11, 2007	3:50pm	WC PT
riday April 13, 2007	4:00pm	WC AO
nday April 16, 2007	4:00pm	WC PT
ednesday April 18, 2007	5:30pm	WC AO
riday April 20, 2007	3:50pm	WC PT
nday April 23, 2007	4:00pm	WC PT
ednesday April 25, 2007	4:00pm	WC AO
riday April 27, 2007	4:00pm	WC PT
ednesday May 2, 2007	4:00pm	WC PT FU
riday May 4, 2007	4:00pm	WC FU
ednesday May 9, 2007	5:30pm	WC AO

Gladys Cardenas MD
200 South Ridge St.
Rye Brook, NY 10573

April 11, 2007

ɔointment List for Livingston Walker, #3133 Case#1
ıpleted appts only: Date range: 01/03/2007 -> 04/11/2007

ıday January 8, 2007	5:30pm	Paul Walker WC treatment
inesday January 10, 2007	5:00pm	PT IV /WC
.day January 12, 2007	5:40pm	PT/WC
inesday January 17, 2007	5:10pm	PT/WC
.day January 19, 2007	5:30pm	PT/WC
inesday January 24, 2007	5:40pm	PT/WC
ıday January 29, 2007	5:45pm	WC EM--2 WEEK
inesday February 28, 2007	4:40pm	PT/WC
ıday March 5, 2007	6:00pm	EM/WC review MRI results schedule ROM &
inesday March 14, 2007	6:00pm	WC/AQUA
inesday March 28, 2007	5:30pm	WC PT FU
ıday April 2, 2007	4:30pm	WC FU
inesday April 4, 2007	6:00pm	AQUA/WC
ıday April 9, 2007	3:50pm	WC PT
inesday April 11, 2007	3:50pm	WC PT

RYE
RADIOLOGY
ASSOCIATES, LLP

FILED IN PAPER CHART

DIAGNOSTIC RADIOLOGY and BREAST IMAGING CENTER

#80511

February 28, 2007

Gladys Cardenas, MD
200 S. Ridge St.
Rye Brook, NY 10573

Re: Walker, Livingston
DOB: 08/21/55

Dear Dr. Cardenas:

LUMBOSACRAL SPINE MRI

Examination was performed with 5mm sagittal fast spin echo T2 weighted images, 5mm T1 weighted images in sagittal projection and 5mm axial T1 weighted images and 5mm fast spin echo T2 weighted images with additional in and out-of-phase sagittal images.

There is normal marrow signal present. There is desiccation of the L5-S1 disc with some mild posterior spur formation and bulging of the annulus.

At L1-2, L2-3 and L3-4, there is no significant bulging of the annulus. No disc herniations, no spinal stenosis is seen.

At L4-5, there is minimal bulging of the annulus present. No disc herniations are present. Mild ligamentum flavum hypertrophy is seen.

At L5-S1, there is bulging of the annulus diffusely. No spinal stenosis is seen. Ligamentum flavum hypertrophy is also noted at this level.

Continued on page -2-

DIANE C. LoRUSSO, M.D. GAIL A. CALAMARI, M.D.

30 RYE RIDGE PLAZA RYE BROOK, NY 10573 Tel 914/253-9200 Fax 914/253-8827
www.ryeradiology.com

RYE
RADIOLOGY
ASSOCIATES, LLP

DIAGNOSTIC RADIOLOGY and BREAST IMAGING CENTER

Gladys Cardenas, MD 02/28/07

Page: 2 Re: Walker, Livingston

IMPRESSION:

Degenerative disc changes at L5-S1. No evidence of disc herniation.

Diffuse disc bulge at L4-5 and to a greater degree at L5-S1.

Ligamentum flavum hypertrophy at L4-5 and L5-S1.

Sincerely yours,

Diane C. LoRusso, MD

DCL/feh
D: 02/28/07 T: 03/01/07

DIANE C. LoRUSSO, M.D. GAIL A. CALAMARI, M.D.

30 RYE RIDGE PLAZA RYE BROOK, NY 10573 Tel 914/253-9200 Fax 914/253-8827
www.ryeradiology.com

RYE
RADIOLOGY
ASSOCIATES, LLP

FILED IN PAPER CHART

DIAGNOSTIC RADIOLOGY and BREAST IMAGING CENTER

#80511

3/13/07

Gladys Cardenas, M.D.
200 South Ridge Street
Rye Brook, NY 10573

RE: Walker, Livingston
DOB: 08/21/55

Dear Dr. Cardenas:

LUMBOSACRAL SPINE X-RAYS

History: Low back pain.

Four different images of the lumbosacral spine reveal the interlumbar disc spaces to be preserved. No evidence of fracture or destructive bony change is seen. The alignment of the lumbosacral segments is satisfactory. The paravertebral soft tissues are unremarkable.

IMPRESSION:

Unremarkable lumbosacral spine study.

Sincerely yours,

Mark W. Fenzl, M.D.

MWF/jb
D: 3/13/07 T: 3/13/07

DIANE C. LoRUSSO, M.D. GAIL A. CALAMARI, M.D.

30 RYE RIDGE PLAZA RYE BROOK, NY 10573 Tel 914/253-9200 Fax 914/253-8827
www.ryeradiology.com

Westchester Medical Center
Maria Fareri Children's Hospital (914)493-7000

ent Name : LIVINGSTON WALKER **Date of Service :** 11/14/2006

Age : 51YRS **Sex :** M **Medical Record # :** 1265623

Follow up with Dr. In 1 Day (s)

ED Phy : Jarvis, Edward
Private Physician

ED Nurse : McGowan, Jean
Referral

My signature below indicates that I have received and understood the oral instructions regarding my medical problem. I acknowledge receipt of this written instruction sheet, which I will read and review. I arrange for follow up care indicated above.

Patient or Legal Guardian signature

 dx_instr

Response Within 5 Days is Required

RETURN TO THIS ADDRESS WITHIN 5 DAYS:
Hospital Receivables Systems, Inc.
PO Box 907
Hicksville, NY 11802-0907

CING INSURANCE COVERAGE UNDER A WORKERS'
R AUTOMOBILE (MEDICAL PAYMENT) POLICY

vables Systems, Inc. to assist it in billing and securing payment from
als injured in the course of their employment) and automobile insurers (in the case of individuals injured through the use or operation of an automobile). In order to ensure that the insurance company is timely and correctly billed, thereby ensuring their consideration of your bill for services rendered by the hospital, it is imperative that you complete and return this form to Hospital Receivables Systems, Inc. If you have any questions or require assistance, call Hospital Receivables Systems, Inc at (516) 227-6330. This form can also be faxed to (516) 227-6342.

Patient Name: LIVINGSTON WALKER
Patient Address:
70 PEARL STREET
PORT CHESTER, N.Y. 10573
Name of Employer: Local 137 Operating Engineers
Address of Employer: 1360 Pleasantville Road
Briarcliff Manor, NY 10510

Date of Birth: 8/21/55
Social Security #: 072-52-5988
Home Telephone #: 203-981-0595 (cell)
Work Telephone #: 914-762-0660
DISPATCHED TO George A. Fuller, Co., Inc.
115 Stevens Avenue
Valhalla, NY 10595

For Automobile No-Fault Insurance Claims:

PER NYS LAW, ALL NO-FAULT BILLS MUST BE SUBMITTED WITHIN 45 DAYS FROM THE DATE OF SERVICE. PLEASE RESPOND PROMPTLY. FAX TO (516)227-6342.

Name of Insurance Carrier :
Address of Insurance Carrier:

Telephone #:
Policy #:
Claim #:
Date of Accident:

Name of Insured:
Address of Insured:

For Workers' Compensation Claims:

Name of Compensation Carrier :
Address of Insurance Carrier:

Policy #:
Claim #:
Telephone #:
Date of Accident:

WCB Case #

Do you have an attorney? _____ Yes _____ No
If yes:
Name and address of Attorney: _____ Telephone # _____

ASSIGNMENT OF BENEFITS (NO-FAULT ONLY)

I, _____, ("Assignor") hereby assign to the above provider, ("Assignee") all rights and privileges and remedies to which I am entitled under Article 51 (the No-Fault provisions) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided to said Assignee for injuries sustained due to the motor vehicle accident which occurred on the above date, notwithstanding any prior written agreement to the contrary.

This agreement shall become null and void if at any time it is determined that the benefits are not payable due to the following circumstances: lack of coverage, violation of a policy condition, or determination that the treatments/services rendered are not related to said motor vehicle accident.

In consideration of the services rendered by Westchester Medical Center, I hereby authorize payment to be made directly to the hospital of any insurance benefit due.

Dated: _____ Signed: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the hospital to release any medical information to the insurance carrier in order for the carrier to process my claim for benefits.

Dated: _____ Signed: _____

Westchester Medical Center
Maria Fareri Children's Hospital (914)493-7000

ent Name : LIVINGSTON WALKER Date of Service : 11/14/2006

Age : 51YRS Sex : M Medical Record # : 1265623

AFTERCARE INSTRUCTIONS

Important: The emergency medical care you received today has been directed towards treatment of your acute condition. Such treatment is not meant to be a substitute for your continuing, comprehensive health care. You must therefore contact your doctor, or the doctor whose name was given today, and let him/her know about your problem today, and the testing and/or treatment you received. That doctor should see you in for a follow-up visit and reevaluate your condition and overall health, with special attention to a review of any lab tests, images, or EKGs done today. If you had any specialized tests, such as EKG's or X-Rays, they will be reviewed and you will be contacted if there is any additional information.

We want to make sure you were happy with the care in the Emergency Department today. You will receive a Survey in the mail. Please mail it back, even if it is just to tell us you were happy - we need to know! And, if you were unhappy with the care, also tell us on the survey, or call the Patient Representative Office at any time.

After leaving the Emergency Department, follow the instructions below.

ABDOMINAL PAIN:
Your examination today has not revealed the exact cause of your abdominal pain. Since abdominal pain can be caused by many different things that may not be apparent right now, further examination, lab tests, ultrasound, or CT scans may be needed. Please follow up with your doctor, or doctor whose name was given to you today, for further evaluation as instructed. You will need to speak to your doctor or return to the emergency room at once if you have any of the following symptoms:

* Increasing pain, or constant pain, especially if it is on the right side.
* Pain that is not improved in 24 hours.
  New, or increased loss of appetite
  Repeated vomiting or dehydration.
* A high fever, weakness, or fainting.
* Black or bloody stools.
* Bloody urine, frequent or painful urination, or decreased urination.
* In women, abnormal bleeding or discharge from the vagina.

Your symptoms should improve within one day, and not worsen. You should be able to walk without pain, and although you may have occasional pain, it should not be present all the time. You should soon be able to drink fluids without vomiting.

You should remain at rest until your pain improves. You may drink clear liquids if you do not have nausea or vomiting. You can increase your activity and begin to eat solid foods as your symptoms improve.

Take the prescribed medication, if any, as directed. All medications have potential side effects, including drowsiness. Don't drive or operate machinery until you have made sure drowsiness is not a side effect; check with your pharmacist and read about each medication prior to taking it.

 dx_instr

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

EMPLOYER'S REPORT OF WORK-RELATED ACCIDENT/OCCUPATIONAL DISEASE

Send this notice directly to the Chair, Workers' Compensation Board at the address shown on the reverse side within ten (10) days after an accident occurs. ANSWER ALL QUESTIONS FULLY. A copy should also be provided to or retained by your workers' compensation insurance carrier.

Any employer who fails to timely file Form C-2, as required by Section 110 of the Workers' Compensation Law, is subject to a fine of not more than $1,000. In addition, the Board or Chair may impose a penalty of up to $2,500.

- TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED - INCLUDE ZIP CODE IN ALL ADDRESSES-EMPLOYEE'S S.S.NO. MUST BE ENTERED BELOW.

WCB CASE NO.(If Known)	CARRIER CASE NO.	CARRIER CODE NO.	WC POLICY NO.	DATE OF ACCIDENT	EMPLOYEE'S S.S. NO.
		W	WC 128-24-27	11/14/06	072-52-5998

1 (a) EMPLOYER'S NAME	(b) EMPLOYER'S MAILING ADDRESS	(c) OSHA CASE/FILE NO.
George A. Fuller Co.	115 Stevens Ave., Valhalla, NY 10595	

(d) LOCATION (If Different From Mailing Address)	(e) NATURE OF BUSINESS (Principal Products, Services, etc.)	(f) NY UI EMPLOYER REG. NO.	(g) FEIN - if UI Emp. Reg. No. Unknown

2.(a) INSURANCE CARRIER	(b) CARRIER'S ADDRESS
AIG Companies	NY, NY

3.(a) INJURED EMPLOYEE (First, M.I., Last)	(b) ADDRESS (Includes No. & Street, City, State, Zip & Apt. No.)
LIVINGSTON WALKER	70 PEARL ST. PORT CHESTER, NY 10573

ACCIDENT

4 (a) ADDRESS WHERE ACCIDENT OCCURRED: 221 MAIN ST WHITE PLAINS NY 10601

(b) COUNTY: WESTCHESTER

(c) WAS ACCIDENT ON EMPLOYER'S PREMISES? ☑ Yes ☐ No

5. HOUR EMP. BEGAN WORK: ☐ AM ☐ PM

6. TIME OF ACCIDENT: 12:10 ☐ AM ☑ PM

7. DEPT. WHERE REGULARLY EMPLOYED: TOWER "A" HOIST

8.(a) DATE STOPPED WORK BECAUSE OF THIS INJURY/ILLNESS: 11/14/06

(b) WAS EMPLOYEE PAID IN FULL FOR DAY? ☑ Yes ☐ No

INJURED

9. SEX: ☑ Male ☐ Female

10. DATE OF BIRTH: 03/21/55

11. OCCUPATION (Specific job title at which employed): HOIST OPERATOR

12. DATE HIRED: 05/03/06

13.(a) AVERAGE EARNINGS PER WEEK? $2500.00

(b) TOTAL EARNINGS PAID DURING 52 WEEKS PRIOR TO DATE OF ACCIDENT (Include bonuses, overtime, value of lodging, etc.): $

14. (a) EMPLOYEE IS: ☐ Full Time ☐ Part Time

(b) INJURED EMPLOYEE'S WORK WEEK (Check days usually worked.): Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐

NATURE OF INJURY

15 NATURE OF INJURY AND PART(S) OF BODY AFFECTED: TORSO

16 (a) DID YOU PROVIDE MEDICAL CARE? ☑ Yes ☐ No

(b) IF YES WHEN? IMMEDIATELY

OXYGEN EMS

17. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ Yes ☐ No

18. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☑ Yes ☐ No

19 (a) NAME AND ADDRESS OF DOCTOR: MD ON DUTY

(b) NAME AND ADDRESS OF HOSPITAL: WESTCHESTER MEDICAL CENTER VALHALLA, NY 10595

20. (a) HAS EMPLOYEE RETURNED TO WORK? ☑ Yes ☐ No

(b) IF YES, GIVE DATE: 11/18/06

(c) AT WHAT WEEKLY WAGE? SAME

NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS

CAUSE OF ACCIDENT

21. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)

OPERATING HOIST (LOADING)

22 HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)

MOTORIZED MORTAR BUGGY ENTERED HOIST AND PINNED L. WALKER TO BACK OF HOIST

23. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE. e.g., the machine employee struck against or which struck him/her, the vapor or poison inhaled or swallowed, the chemical that irritated his/her skin. In cases of strains, the thing (s)he was lifting, pulling, etc.

FATAL CASES

24. (a) DATE OF DEATH:

(b) NAME AND ADDRESS OF NEAREST RELATIVE: LINDA WALKER - SAME

(c) RELATIONSHIP: WIFE

PREPARATION

DATE EMPLOYER/SUPERVISOR FIRST KNEW OF INJURY: 11/14/06

DATE OF THIS REPORT: 12/27/06

IF FORM IS SUBMITTED BY EMPLOYER, COMPLETE A & B BELOW.
IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A,B,C & D BELOW.

A. EMPLOYEE PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY

B. TITLE — TELEPHONE NUMBER & EXTENSION

C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS

D. THIRD PARTY CONTACT NAME — TELEPHONE NUMBER & EXTENSION

OFFICIAL NEW YORK STATE PRESCRIPTION

KENNETH E FOX MD
104 EAST 40TH STREET
SUITE 807
NEW YORK, NY 10016
(212) 304-1950
LIC. 60-187830

PRACTITIONER DEA NUMBER
BF 4302256

Patient Name Lelikan Livingston Date 1-8-07

Address

City State Zip Age Sex M F

Rx Tercocet 75/500
take 1 TID PRN
#90

Prescriber Signature X

MAXIMUM DAILY DOSE (controlled substances only) 6

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'daw' IN BOX BELOW.

REFILLS None Refills

PHARMACIST TEST AREA

Dispense As Written

0FB5CL 23

AFFIDAVIT OF SERVICE BY MAIL

STATE OF NEW YORK)
) ss.:
COUNTY OF WESTCHESTER)

Catherine McEvily, being duly sworn, says:

I am not a party to the action, am over 18 years of age and reside at Larchmont, New York.

On November 14, 2007 I served a true copy of the annexed **RULE 26 DISCLOSURE**, by mailing the same in a sealed envelope, with postage prepaid thereon, in a post-office depository of the U.S. Postal Service within the State of New York, addressed to the last known address of the addressees as indicated below:

To: I. Paul Howansky, Esq.
HARRINGTON, OCKO & MONK, LLP
Attorneys for Defendants
LC MAIN, LLC and ROGER & SONS CONCRETE, INC.
81 Main Street, Suite 215
White Plains, New York 10601
(914) 686-4800

Catherine McEvily

Sworn to before me this
14th day of November, 2007.

Notary Public

Z:\Katie\WP\Marion, Carisa\AFOS Rule 26 wpd

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[illegible] County
[illegible] 16, 20[illegible]0